Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

WILLIAM DAVIS,

Petitioner

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA, AND REGAL-BELOIT CORPORATION LONG TERM DISABILITY PLAN

Respondents

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Three interrelated questions are presented in this petition:

1) Whether courts adjudicating ERISA civil actions may substitute administrative law procedures for the discovery, pre-trial and trial procedures set forth in the Federal Rules of Civil Procedure?

2) Whether *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989) and *Black & Decker Disability Plan v. Nord,* 538 U.S. 822 (2003), require courts to perform a threshold inquiry into the reliability of the evidence utilized by a conflicted ERISA plan administrator?

3) Whether an insurer that both funds and administers an employee benefit program satisfies the "full and fair review" requirement of 29 U.S.C. § 1133(2) when it denies a claim solely in reliance on conclusory findings made by its own employees while disregarding all other evidence?

LIST OF PARTIES

The parties to this action are all listed in the caption: William Davis, plaintiff; Unum Life Insurance Company of America, claim administrator and payor of benefits, defendant; and Regal-Beloit Long Term Disability Benefit plan, plan sponsor, defendant.

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OPINION BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit was issued on April 5, 2006 and is reported as *Davis v. Unum Life Ins. Co. of Am.*, 444 F.3d 569 (7th Cir. 2006)(Reprinted at Appendix 1a-17a). The Court of Appeals reversed an award of summary judgment issued in favor of the plaintiff by the United States District Court for the Northern District of Illinois on March 31, 2005 (Appendix 18a-52a). The district court's order was unpublished.

Rehearing of the Court of Appeals decision was denied on April 24, 2006 (App. 53a-54a).

STATEMENT OF JURISDICTION

This Court's jurisdiction is invoked under 28 U.S.C. §1254(1). The initial subject matter jurisdiction was derived from 29 U.S.C. §§ 1132(e)(1) and (f), and 28 U.S.C. § 1331, as this matter arose under the Employee Retirement Income Security Act, a federal law.

The Seventh Circuit's opinion was issued on April 5, 2006. Rehearing was denied on April 24, 2006.

STATUTORY PROVISIONS AND COURT RULES INVOLVED

Title 29, United States Code, Section 1132(a) states:

(a) Persons empowered to bring a civil action. A civil action may be brought--
(1) by a participant or beneficiary—
(B) to recover benefits due to him under

the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

Federal Rules of Civil Procedure 1 and 2 state in relevant part:

Rule 1. Scope and Purpose of Rules.

These rules govern the procedure in the United States district courts in all suits of a civil nature whether cognizable as cases at law or in equity or in admiralty, with the exceptions stated in Rule 81...

Rule 2. One Form of Action.

There shall be one form of action to be know as "civil action."

Federal Rule of Civil Procedure 26(b)(1) states in relevant part:

Parties may obtain discovery regarding any matter, not privileged that is relevant to the claim or defense of any party...

Federal Rule of Civil Procedure 56(c) states in relevant part:

[Summary judgment] shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any

material fact and that the moving party is entitled to a judgment as a matter of law.

Federal Rule of Civil Procedure 56(e) states in relevant part:

Supporting and opposing affidavits shall be made on personal knowledge, shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein.

STATEMENT OF THE CASE

A. The Statutory Framework

1. The ERISA law authorizes employee benefit plan participants to bring a civil action "to recover benefits due … under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B) (2006).

2. In authorizing civil actions under the ERISA law, Congress did not suspend the applicability of the Federal Rules of Civil Procedure. The Federal Rules apply to "all suits of a civil nature whether cognizable as cases at law or in equity" with the exception of certain types of cases enumerated in Rule 81. Rule 1. The Federal Rules of Civil Procedure also provide for "one form of action to be known as 'civil action." Rule 2.[1]

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[1] The applicability of the Federal Rules of Civil Procedure to ERISA suits is also raised in the pending petition for *certiorari* filed in *Semien v. Life Ins. Co. of N. Am.*, No. 05-1386. Counsel for Petitioner in this matter also represents petitioner in *Semien*, and given the relatedness of the

3. Prior to bringing a civil action, participants whose benefits have been denied in whole or in part have a right to a "full and fair review" of the claim determination conducted in accordance with regulations promulgated by the Secretary of Labor. 29 U.S.C. § 1133(2) (2006), 29 C.F.R. § 2560.503-1 (2006). The claims process was intended to be an efficient, non-adversarial means of resolving benefit disputes. *Amato v. Bernard,* 618 F.2d 559, 567 (9th Cir. 1980).

4. The plan's obligation to provide a full and fair review was never intended as a substitute for plenary civil proceedings. The ERISA Conference Committee drafted section 503 as a compromise between the original House Bill, which had no such provision, and the draft Senate Bill, which provided for review and arbitration of benefit disputes. H.R.Rep.No.93-1280, 93d Cong., 2d Sess., reprinted in 1974 U.S.Code Cong. & Admin. News 5038, 5108.

5. Rule 56(c) of the Federal Rules of Civil Procedure allows a court to grant summary judgment to a litigant only where "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law."

6. According to *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 249-250 (1986), in evaluating summary judgment, "the judge's function is not himself to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson* further

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issues in both this case and that matter, suggests the two cases be consolidated if *certiorari* is granted.

noted that Rule 56(f) provides "that summary judgment be refused where the nonmoving party has not had the opportunity to discover information that is essential to his opposition." *Id.* at 250 n.5.

7. The Federal Rules of Civil Procedure permit parties to "obtain discovery regarding any matter, not privileged, that is relevant to the claim or defense of any party . . . . For good cause, the court may order discovery of any matter relevant to the subject matter involved in the action. Relevant information need not be admissible at the trial if the discovery appears reasonably calculated to lead to the discovery of admissible evidence." Fed.R.Civ.P. 26(b)(1).

8. The Federal Rules of Evidence also require as a threshold to admissibility of opinion evidence that

> 1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

Federal Rule of Evidence 702. The Federal Rules of Evidence apply to all actions and proceedings in the district courts. Fed.R.Evid. 101, 1101.

B. Procedural Background

9. Petitioner, William Davis, brought this action pursuant to the ERISA law, 29 U.S.C. § 1132(a)(1)(B), seeking disability insurance benefits. Davis, a sales manager for the Regal-Beloit Corporation, initially qualified to receive benefits under a disability plan sponsored by his employer and underwritten by the Unum Life Insurance

Company of America. However, Unum later discontinued Petitioner's benefits and Davis commenced a civil action seeking to recover benefits due.

The district court granted summary judgment to Petitioner and remanded the case to Unum to render a new determination[2] after finding the insurer arbitrarily and capriciously

> (1) relied on the conclusory and unsupported opinions of in-house doctors who had not examined Plaintiff; (2) relied on opinions of in-house doctors who had not examined plaintiff and who did not explain their basis for disagreement with the conclusions reached by Plaintiff's treating physicians; (3) failed to contact Plaintiff's treating physicians to discuss their diagnoses; (4) failed to refer Plaintiff to an independent medical expert for examination; and (5) ignored (or at least made no mention of) evidence and reports presented by Plaintiff's treating physicians.

Pet.App. 42a-43a.

10. The district court's opinion also criticized Unum's reliance on outdated evidence (Pet.App. 48a n.15) and further explained:

> The administrative record reflects a pattern in which Unum doctors briefly discuss the medical testing (in a sentence or two), and

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[2] Plaintiff appealed the remand order contending there was no statutory or other basis for such an order, unlike Social Security cases. *See, e.g.*, 42 U.S.C. § 405. That aspect of the case was not discussed in the opinion rendered by the Court of Appeals.

> then conclude "but Plaintiff's impairments do not render him physically unable to perform sedentary work." At no point do they attempt to explain their own conclusions or their basis for disagreeing with the conclusions of Plaintiff's treating physicians.

Pet.App. 45a.

11. The Court of Appeals reversed and entered summary judgment for the Respondent. Pet.App. 1a-17a. The Seventh Circuit ruled that Unum satisfactorily fulfilled its fiduciary obligations under the ERISA statute by utilizing in-house physicians the court characterized as "independent" of its lay claim staff. Pet.App. 9a. The court added that Petitioner had failed to show "that the doctors in this case had any specific incentive to de-rail his claim" (Pet.App.10a).

12. However, Petitioner was precluded from making any showing that the Unum doctors' findings were less reliable than the clinical observations and conclusions drawn by the treating doctors. During the course of the litigation, Petitioner sought, but was denied the opportunity to take discovery to determine whether Unum and its physicians performed a full and fair review of Davis's medical records as the ERISA statute requires, 29 U.S.C. § 1133(2). The objection to Petitioner's request for discovery was based on long-standing Seventh Circuit precedent, *Perlman v. Swiss Bank Corp.*, 195 F.3d 975 (7th Cir. 1999) which limits the court's role in adjudicating ERISA claims solely to a review of the claim record. R. 8, 9, 11.

C. William Davis's Medical Condition

William Davis, a 62 year old resident of Antioch,

Illinois, is a former employee of the Regal-Beloit Corporation where he worked as a sales manager. As part of his compensation, Davis received employer-sponsored disability insurance coverage underwritten by the Unum Life Insurance Company of America ("Unum"), a subsidiary of the publicly held UnumProvident Corporation.

Davis ceased working in January 2000 after he suffered a stroke; and on account thereof, he applied for and began receiving disability benefits from Unum. Unum stopped paying benefits after two years, though, even though the policy provides for benefit payment to age 65. Although Unum acknowledged that Davis remains totally disabled, the insurer asserted that the disability was due to psychiatric reasons; and the policy limits the duration of benefit payments for disabilities due to mental and nervous disorders to a maximum of 24 months.

William Davis suffers from many chronic and debilitating medical conditions: diabetes mellitus, anticardiolipin antibody syndrome, a history of transient ischemic attacks, coronary artery disease, sleep apnea, lumbar spinal stenosis, carpal tunnel syndrome, a history of prostate cancer, and post-polio syndrome. In assessing the combined effect of Davis's physical conditions, and explaining why Davis is disabled independent of any psychiatric impairments, one of his physicians, Michael Raymond, M.D., pointed out:

> As the sum total of the above conditions, I have found Mr. Davis to be significantly impacted on a purely physical basis. He ambulates with the assistance of a wheeled walker due to a combination of leg weakness from postpolio syndrome and pain from spinal stenosis. These conditions make it difficult, if not impossible, for Mr. Davis to sit, stand or walk for any

> prolonged timeframes. He experiences numbness of his hands from carpal tunnel syndrome, which would preclude an excessive amount of writing or activities involving fine manipulative abilities or repetitive type activities. He has most recently had an episode of hypoglycemia in which he was found driving on the wrong side of the street incoherent requiring acute hospitalization, this secondary to his diabetes.
>
> I have reviewed the Social Security Administration definition of work activities and under that of sedentary work I do not believe Mr. Davis to be able to complete even that, i.e., exerting up to 10 pounds of force occasionally or a negligible amount one-third to two-thirds of the time in activities such as lifting, carrying, pushing, pulling or moving objects. In sum, I do not believe that Mr. Davis is capable of active employment at this time based on the above conditions.

UACL 00658-00658. Neurologist Steven Myers, M.D., another treating doctor, corroborated Dr. Raymond's findings:

> Mr. Davis has lumbar spinal stenosis superimposed upon his polio. He also appears to have suffered a small stroke in December 2000 with some mild residual right-sided weakness. While any one of these particular problems may not be terribly disabling, I believe the combination of the three has resulted in permanent disability. Mr. Davis cannot stand or walk for any distance and has significant lower extremity weakness. I

> believe that he is presently disabled from the lumbar spinal stenosis and the polio.

UACL 00306.

Although Unum credited those diagnoses, and even acknowledged Davis's use of an assistive device to aid in walking, the insurer's in-house doctors who reviewed Davis's records summarily determined there was no "clear evidence" that sedentary level work would be precluded. UACL 00628. Without contacting either Dr. Raymond or Dr. Myers, Unum's employee physicians concluded solely from their review of the medical records that Davis could perform the physical duties of a sales manager or an alternate occupation.

Based on its review of the claim record, the district court found Unum's evaluation of the claim arbitrary and capricious and remanded the case to Unum for a redetermination. On appeal, however, the Court of Appeals rejected the district court's rationale and held that under an arbitrary and capricious standard of review, Unum had no obligation to seek an independent assessment from consultants other than Unum employees. The court also accepted without question the conclusions reported by the Unum doctors even though Petitioner had been denied discovery or an opportunity to cross-examine the authors of those reports to investigate bias or error in their findings. Without any evidentiary proceeding at all, the Court of Appeals concluded that Davis's physicians were "advocates," while Unum's in-house doctors were "independent" (Pet.App. 9a, 14a) and that it was appropriate for Unum, and ultimately the court, to defer to their findings.

The Seventh Circuit's ruling is inconsistent with the ERISA statute, the Federal Rules of Civil Procedure, and Supreme Court rulings; and is in direct conflict with rulings

issued by the Sixth and Tenth Circuits, as well as with other panel rulings issued by the Seventh Circuit.

REASONS FOR ALLOWANCE OF THE WRIT

I. The ERISA Requirement that Plan Administrators Utilize Reliable Evidence Was Undermined by the Seventh Circuit's Decision

This case requires resolution of fundamental civil procedure and evidentiary issues in ERISA civil actions. The Supreme Court decided one major procedural issue in *Black & Decker Disability Plan v. Nord,* 538 U.S. 822 (2003). However, many other issues remain unresolved. In *Nord,* the treating physician's opinion was controverted by an independent *examining* doctor. Under such circumstances, the Court ruled that benefit plans were not required to give automatic deference to contrary treating physicians' findings. Instead, the Court directed that benefit decisions should be based on all available *reliable* evidence. In this case, however, and in a large number of health and disability benefit claims, the plan administrator's determination resulted from a review of medical records by physicians in the insurer's employ who never examined the claimant. The Court of Appeals lacked any evidentiary grounds for crediting the reliability of those opinions.

A. The Seventh Circuit Improperly Substituted Administrative Procedures for The Federal Rules of Civil Procedure

1. The Impropriety of an Administrative Law Paradigm

The Seventh Circuit improperly accorded deference to Unum's findings and granted Respondent summary

judgment without giving Petitioner any means of challenging the reliability of the insurer's determination. In effect, the Court of Appeals substituted an administrative law model for the adjudication of civil actions brought pursuant to 29 U.S.C. § 1132(a)(1)(B) for application of the Federal Rules of Civil Procedure. However, ERISA claims are not amenable to such procedures. Judge Henry Friendly pointed out in his landmark law review article, "Some Kind of Hearing," 123 U. Pa. L. Rev. 1267, 1279-95 (1975) that several elements are necessary for a fair administrative hearing: 1) an unbiased tribunal; 2) notice of the proposed action and the grounds asserted for it; 3) an opportunity to present reasons why the proposed action should not be taken; 4) the right to call witnesses, including the right to cross-examine adverse witnesses; 5) the right to know the evidence at issue; 6) the right to have a decision based on the evidentiary record; 7) the right to counsel; 8) a record; 9) articulated reasons for the decision; 10) public attendance; and 11) judicial review.

Although the ERISA claim regulations, at 29 C.F.R. § 2560.503-1 (2006) provide many of the necessary guarantees, the most crucial protections are denied ERISA claimants. Particularly in claims brought pursuant to insurance policies, the claim review process lacks the neutrality inherent in agency determinations. As *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1183 (3d Cir. 1991) pointed out in the ERISA context:

> Plan administrators are not governmental agencies who are frequently granted deferential review because of their acknowledged expertise. Administrators may be laypersons appointed under the plan, sometimes without any legal, accounting or other training preparing them for their

> responsible position, often without any experience in or understanding of the complex problems arising under ERISA, and, as this case demonstrates, little knowledge of the rules of evidence or legal procedures to assist them in factfinding.

The Seventh Circuit itself acknowledged in *Ramsey v. Hercules, Inc.*, 77 F.3d 199, 204 (7th Cir. 1996) that ERISA claims are not analogous to administrative law claims:

> Crucial differences exist between findings of fact made by a private entity such as a plan administrator, and findings made by duly authorized administrative law judges, agencies, or federal district courts. Underlying the deferential review that fact findings of the latter bodies enjoy is a well established set of procedural protections that stem from the Constitution and individual statutes. Plan administrators, in contrast, neither enjoy the acknowledged expertise that justifies deferential review for agency cases, see Luby, 944 F.3d at 1183, nor are they unbiased fact finders like the courts. Indeed, when the initial decision in an agency lacks the crucial procedural safeguards, the Administrative Procedure Act requires the federal courts to review both fact and law de novo.

Also see, Herzberger v. Standard Ins. Co., 205 F.3d 327, 332 (7th Cir. 2000)(focusing on the procedural differences between ERISA claims and Social Security claims). The sources of the Seventh Circuit's findings in *Ramsey* and *Herzberger* are drawn from both the Administrative Procedure Act (APA) and Supreme Court precedent.

According to the APA, when an agency's findings lack substantive and procedural due process protections, they are subject to "trial de novo by the reviewing court." 5 U.S.C. 706(2)(F) (2006). As an example, in *Citizens to Preserve Overton Park, Inc. v. Volpe,* 401 U.S. 402 (1971), the Court found that a federal highway administrator's approval of funding for a highway that traversed a public park lacked adequate factual findings relating to an alternate route as required by law. The district court was therefore ordered to conduct a plenary hearing of the dispute. *Id.* at 420.

Moreover, in contrast to the unbiased factfinding in administrative law claims, William Davis's disability benefit determination was decided by doctors whose livelihood is dependent on the profitability of the UnumProvident Corporation. Undermining the Seventh Circuit's presumption of physician independence, *Bennett v. Unum Life Ins. Co. of Am.,* 321 F.Supp.2d 925, 933-34 (E.D.Tenn. 2004) recited sworn testimony from a former Unum physician describing how Unum's "Medical advisors ... are offered bonuses at a level of 25% base pay determined, in part, on company earnings. Medical advisors are also eligible to participate in stock option grants with the company upon management's recommendation and the Compensation Committee's approval." Consequently, the very employees whose opinions are used to decide claims profit directly from claim denials.

In addition, a governmental investigative report included in the record on appeal raises further questions about whether Davis received a full and fair review. Petitioner submitted the Multistate Market Conduct Study ("MCS") performed by the insurance commissioners of 49 states and by the United States Department of Labor, along with a remedial Regulatory Settlement Agreement ("RSA"). (R. 28). That report raised significant concerns relating to

systemic unfair claims adjudication practices by Unum identical to the ones presented in this matter. Specifically, the regulators identified the following areas of concern: (1) excessive reliance upon in-house medical professionals; (2) unfair construction of attending physician or IME reports; (3) failure to evaluate the totality of the claimant's medical condition; and (4) inappropriate burden placed on claimants to justify eligibility for benefits. Market conduct report, November 18, 2004 at 6-8.

The only non-participating state, California, issued its own report in October 2005 based on a sampling of approximately 350 Unum claims adjudicated at the same time as Davis's benefits were undergoing review. The report of the California Market Conduct Investigation found nearly one out of three claims were improperly evaluated. http://www.insurance.ca.gov/0400-news/0100-press-releases/0080-2005/upload/market-conduct-exam-report.pdf. In response, Unum agreed to significantly modify its claims practices in a way that, if applied here, would have fundamentally changed the claim review accorded William Davis's claim. http://www.insurance.ca.gov/0400-news/0100-press-releases/0080-2005/upload/CSA. pdf. Davis would have had a right to an *independent examination,* and his treating doctors' reports would have been given far more weight as a means of providing a fairer claims appraisal.

Many courts have also expressed doubt about the fairness of Unum's treatment of its insureds under the ERISA law. A listing of scores of court rulings finding Unum and its affiliates guilty of arbitrary and capricious behavior catalogued in *Radford Trust v. First Unum Life Ins. Co. of Am.*, 321 F.Supp.2d 226, 247 n.20 (D.Mass. 2004)[3]

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[3] That listing includes two notable examples: *Dishman v. UNUM Life*

reinforces the regulators' conclusions and further challenges the Seventh Circuit's assumptions about Unum's doctors. Indeed, in view of those findings, the Seventh Circuit had no basis for deeming Unum's doctors "independent" without any evidentiary basis for doing so.

Nor can the Seventh Circuit's application of an administrative law paradigm be ascribed to application of the arbitrary and capricious standard of review. In *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 385 (2002), the Court found:

> [ERISA] requires plans to afford a beneficiary some mechanism for internal review of a benefit denial, 29 U.S.C. § 1133(2), and provides a right to a subsequent judicial forum for a claim to recover benefits, § 1132(a)(1)(B). Whatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of primary conduct, *not a uniformly lenient regime of reviewing benefit determinations.* (citation omitted)(emphasis added).

Ins. Co. of Am., 1997 U.S. Dist. LEXIS 22676, No. 96-0015-JSL, 1997 WL 906146, at *11-13 (C.D. Cal. May 9, 1997) (describing UNUM Life's "unscrupulous conduct" in engaging in "bad faith denial of large claims as a strategy for settling them for substantially less than the amount owed") and *Hines v. UNUM Life Ins. Co. of Am.*, 110 F. Supp. 2d 458, 460-61 (W.D. Va. 2000) (noting the "scathing failure by UNUM Insurance to impartially administer the disability plan"). *Also see, Watson v. UNUMProvident Corp.*, 2002 WL 246579, CIV.AMD 01-1316 (D.Md.2/19/[illegible] (citing Unum's "unreasonable and unprincipled deliberative process [illegible].

Accordingly, even under a deferential standard of review, the Seventh Circuit had no grounds for insulating Unum's decision from meaningful judicial review. The court of appeals has essentially given a private insurer more authority and less penetrating review of its claim determinations than an administrative agency such as the Social Security Administration would receive. A dissent in *Perlman v. Swiss Bank Corp.*, 195 F.3d 975 (7th Cir. 1999), warned that the absence of plenary proceedings in ERISA claims "effectively preclude[s] as a matter of law any procedural challenge to an ERISA plan administrator's decisions, thereby giving those decisions a uniquely privileged position in the entire field of administrative or quasiadministrative law." 195 F.3d at 983 (Wood, J., dissenting). Likewise, as a leading ERISA scholar has pointed out

> Deciding a case on the merits is indeed more time-consuming than presuming the correctness of somebody else's self-serving decision. Because, however, Congress determined to subject ERISA-plan denials to federal judicial review, and because ERISA's draconian preemption provision suppresses the state law causes of action that existed for many such cases before ERISA, the proper role of the federal courts is to decide these cases fairly and not slough them off onto biased decisionmakers.

Langbein, "Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA" at 34-35 (Draft June 26, 2006 available at http://www.law.yale.edu/faculty/2940.asp).

2. The Seventh Circuit's Ruling Fails Even Under an Administrative Law Paradigm

Nor would the Seventh Circuit's ruling even satisfy necessary due process requirements for administrative procedures. In *Richardson v. Perales,* 402 U.S. 389, 402-406 (1971), the Supreme Court allowed an *examining* physician's report to constitute substantial evidence in a Social Security disability benefit claim and outweigh hearsay objections because nine separately enumerated assurances of trustworthiness were met. None of those protections, which require a report prepared by an independent, percipient witness who had personally conducted a clinical, scientifically valid medical examination, and that the claimant retain the opportunity to cross-examine the author of the report, were present in this case.

Likewise, to the extent the consultants employed by insurers fulfill the function of expert witnesses, absent discovery or cross-examination, the Seventh Circuit lacked any threshold indication that their conclusions meet the requirements of Federal Rule of Evidence 702 which mandates that

> 1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

Accordingly, without discovery or testimonial proceeding, the Seventh Circuit's decision was without an evidentiary foundation. Since cross-examination is "beyond any doubt the greatest legal engine ever invented for the discovery of truth" (5 J. Wigmore, Evidence 1367 (J. Chadbourn rev.

1974)), its absence in this case created a huge void in the truth-seeking process.

3. The Seventh Circuit Improperly Denied Petitioner the Protections of the Federal Rules of Civil Procedure

Moreover, in granting Unum summary judgment, the Seventh Circuit denied Petitioner the protection of Rule 56 of the Federal Rules of Civil Procedure. Summary judgment may only be granted if the admissible evidence before the court demonstrates the absence of any genuine issues of material fact. Rule 56(e). *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249-250 (1986) also admonished federal judges not to engage in factfinding at the summary judgment stage, and to refuse to grant summary judgment "where the nonmoving party has not had the opportunity to discover information that is essential to his opposition." *Id.* at 250 n.5.

Here, however, the Court of Appeals disregarded *Anderson* and weighed the evidence presented without giving Petitioner the opportunity to conduct discovery. While some courts have taken the position that such conduct is appropriate in ERISA actions, which they view as "review proceedings" (*See, e.g., Semien v. Life Ins. Co. of N. Am.*, 436 F.3d 805 (7th Cir. 2006); *cert. pending* No. 05-1386), that analysis is misplaced. According to *Chandler v. Roudebush*, 425 U.S. 840 (1976), which held that suits to redress discrimination in federal employment pursuant to § 717(c) of the Civil Rights Act, 42 U.S.C. §2000e *et seq.* were plenary and not review proceedings, the language of the governing statute dictates the nature of the civil procedure to be followed. The Court explained that a "civil action" normally connotes de novo consideration rather than a record review and added,

> In most instances, of course, where Congress intends review to be confined to the administrative record, it so indicates, either expressly or by use of a term like "substantial evidence," which has "become a term of art to describe the basis on which an administrative record is to be judged by a reviewing court." Ibid. E. g., 5 U.S.C. § 706 (scope-of-review provision of Administrative Procedure Act); 12 U.S.C. § 1848 (scope-of-review provision applicable to certain orders of the Board of Governors of the Federal Reserve System); 15 U.S.C. § 21 (c) (scope-of-review provision applicable to certain orders of the Interstate Commerce Commission, the Federal Communications Commission, the Civil Aeronautics Board, the Federal Reserve Board, and the Federal Trade Commission); 21 U.S.C. § 371 (f)(3) (scope-of-review provision applicable to certain orders of the Secretary of Health, Education, and Welfare).

425 U.S. at 862 n.37.

Chandler's analysis makes it clear that the ERISA law was never intended to provide for review proceedings. Nowhere in either the statute itself or in its legislative history is the term "substantial evidence" utilized. Hence, ERISA claimants are entitled to the full panoply of discovery, pre-trial and trial procedures.

Moreover, Rule 1 of the Federal Rules of Civil Procedure makes the Rules applicable to all civil actions other than those enumerated in Rule 81, with no exception made for ERISA cases. *New Hampshire Fire Ins. Co. v. Scanlon,* 362 U.S. 404, 406 (1960) reinforces an intent that

the Federal Rules of Civil Procedure apply to all civil actions. *Scanlon* ruled that even in tax levies, plenary procedures are required. The Court explained:

> Supplementing the constitutional, statutory, and common-law requirements for the adjudication of cases or controversies, the Federal Rules of Civil Procedure provide the normal course for beginning, conducting, and determining controversies. Rule 1 directs that the Civil Rules shall govern all suits of a civil nature, with certain exceptions stated in Rule 81 none of which is relevant here. Rule 2 directs that "There shall be one form of action to be known as 'civil action.'"

Accordingly, because the Seventh Circuit had no evidentiary basis for concluding the plan denial was based on admissible or even "reliable" evidence, no grounds existed for the grant of summary judgment.

4. The Seventh Circuit Disregarded Unum's Fiduciary Responsibilities

Finally, the Seventh Circuit misperceived the function of an ERISA claim fiduciary. Ironically, the Seventh Circuit's opinion cited two Tenth Circuit rulings against Davis; however, both cases reinforced Petitioner's argument that Unum was under a duty to weigh and give equal consideration all of the evidence. In discussing the responsibilities of a plan fiduciary in adjudicating ERISA disability benefit claims, *Gaither v. Aetna Life Ins. Co.*, 394 F.3d 792, 807-808 (10th Cir. 2004) relied on *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625 (10th Cir. 2003) in explaining:

> Aetna's position seems to be that as a plan fiduciary, it plays a role like that of a judge in a purely adversarial proceeding, where the parties bear almost all of the responsibility for compiling the record, and the judge bears little or no responsibility to seek clarification when the evidence suggests the possibility of a legitimate claim. The authority just cited suggests that Aetna has the wrong model.
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> * * *
>
> While a fiduciary has a duty to protect the plan's assets against spurious claims, it also has a duty to see that those entitled to benefits receive them. It must consider the interests of deserving beneficiaries as it would its own. An ERISA fiduciary presented with a claim that a little more evidence may prove valid should seek to get to the truth of the matter. See Toland, 499 F. Supp. at 1193 (relying on analogous principles governing judicial review of administrative agency decisions).

Indeed, the reason *Gaither* rejected the analogy between ERISA plan administrators and federal judges is that a self-interested insurer lacks the judiciary's independence. Surely, any judge asked to decide a dispute where the judge's personal physician was a crucial witness would recuse pursuant to 28 U.S.C. § 455(a), which provides that "[a]ny justice, judge, or magistrate judge of the United States shall disqualify himself in any proceeding in which his impartiality might reasonably be questioned." The goal of 28 U.S.C. § 455(a) is to "avoid even the appearance of partiality." *Liljeberg v. Health Servs. Acquisition Corp.*, 486 U.S. 847, 860 (1988). Paradoxically, however, the Seventh Circuit has not grasped that lesson.

II. The ERISA Law Requires A Full As Well as a Fair Review

A. The Fiduciary Duty of Loyalty Required Independent Review

Just as *Black & Decker Disability Plan v. Nord, supra.* ruled against granting automatic deference to treating physician opinions in disability claims brought under the ERISA law, no statutory authority or regulation grants plan administrators warrant to abjectly defer to the findings of physicians in their employ. In ruling that the ERISA law "abounds with the language and terminology of trust law" in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 110 (1989), the Court imposed fiduciary responsibilities on parties administering employee benefit claims. Recognizing the importance of a fiduciary's obligation to engage in independent review (Pet.App. 9a), the Seventh Circuit nonetheless disregarded its own decision in *Hightshue v. AIG Life Ins. Co.,* 135 F.3d 1144, 1148 (7th Cir. 1998) in finding Unum's employee-physicians "independent" in administering claims.

Hightshue ruled that when it is "possible to question the fiduciaries' loyalty, they are obliged at a minimum to engage in an intensive and scrupulous independent investigation of their options to insure that they act in the best interests of the plan beneficiaries." Ignoring that principle, though, the Seventh Circuit accorded Unum the right to automatically defer to physicians on its payroll and to disregard the opinions of two physicians who had first-hand clinical knowledge of the claimant's condition.

B. The Court Was Obligated to Conduct An Inquiry Into the Reliability of Unum's Evidence

Despite the application of an arbitrary and capricious standard of review, as the Sixth Circuit explained in *McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161 (6th Cir. 2003), a court's review

> inherently includes some review of the quality and quantity of the medical evidence and the opinions on both sides of the issues. Otherwise, courts would be rendered to nothing more than rubber stamps for any plan administrator's decision as long as the plan was able to find a single piece of evidence-no matter how obscure or untrustworthy-to support a denial of a claim for ERISA benefits. (citing *Hackett v. Xerox Corp. Long-Term Disability Income Plan,* 315 F.3d 771 (7th Cir. 2003), *supra.*)

347 F.3d at 172-73. Due to such concerns, the Sixth Circuit, in *Moon v. UnumProvident Corp.*, 405 F.3d 373 (6th Cir. 2005), cautioned against judicial deference to insurers' benefit determinations based solely on in-house staff physician file revie (including a review from the same Dr. Feagin whose opinion was relied on to terminate Davis's benefits):

> Dr. Feagin's role was not as a neutral independent reviewer, but as an employee of Unum. It is not enough for Unum to offer an explanation for the termination of benefits; the explanation must be consistent with the 'quantity and quality of the medical evidence'

that is available on the record.

Id. at 381. *Moon* further held, in direct conflict with the Seventh Circuit's observations, "When a plan administrator's explanation is based on the work of a doctor in its employ, we must view the explanation with some skepticism." [4] *Id. at* 381-2. Yet another Sixth Circuit case, *Evans v. UnumProvident Corp.,* 434 F.3d 866 (6th Cir. 2006), elaborated further:

> Defendant's reliance solely on file reviews by its in-house physicians is questionable in light of the critical credibility determinations made in those file reviews, the factual inaccuracies contained therein regarding plaintiff's treatment history, and the fact that the file reviews categorically dismissed the reliable opinion of plaintiff's treating physician that the stress factor militated against plaintiff's resumption of her administrative position.

434 F.3d at 880.

Because the findings made by Unum's consultants were adopted without question by the insurer, the Seventh Circuit's conclusion that "it is enough, in situations such as this, for the doctors to review the file and render a professional, medical opinion" (Pet.App. 16a) falls well short of the statutory requirements affording benefit claimants the right to a "full and fair review" of their claims. Nor did the Seventh Circuit's ruling meet *Nord's* requirement that the full and fair review requires the plan administrator to

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[4] As Upton Sinclair wrote, "It is difficult to get a man to understand something when his salary depends upon his not understanding it." *I, Candidate for Governor: And How I Got Licked* (1935)

distinguish between evidence that is reliable and evidence that is not. Those deficiencies are particularly glaring in view of the district court's refusal to allow the plaintiff to take discovery. As Professor Langbein observes, "Plan terms lowering the standard of review undermine the effectiveness of ERISA's requirement of fairness in internal proceedings, by making it so much harder to challenge unfairness." Langbein, *supra.* at 44.

C. The Seventh Circuit Failed to Meet Its Obligation to Weigh Unum's Conflict of Interest

The Seventh Circuit's factfinding in Unum's favor without any consideration of Unum's conflict of interest caused by the tension between its duty to its shareholders and the fiduciary duty it owes to plan participants, was also contrary to *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989), which requires that any potential conflict of interest "must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" The Seventh Circuit is the only Circuit that refuses to recognize the potential for insurer conflicts of interest under the ERISA law. *See, Rud v. Liberty Life Assurance Co.,* 438 F.3d 772 (7th Cir. 2006) as compared to *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 387-89 (3d Cir. 2000); *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997); *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1561-62 (11th Cir. 1990); *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997 (10th Cir. 2004).

Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) reinforces the need to weigh the conflict. There, the Court stated: "In *Firestone Tire* itself we stated that the inquiry would home in on any conflict if a conflict was plausibly raised. . . . It is a fair question just how deferential

the review can be when the judicial eye is peeled for conflict of interest." 536 U.S. at 384 n.15.

For precisely that reason, the Sixth Circuit, in *Calvert v. Firstar Fin., Inc.*, 409 F.3d 286, 292 (6th Cir. 2005), expressed concern about physicians hired to review claims: "As the plan administrator, Liberty had a clear incentive to contract with individuals who were inclined to find in its favor that Calvert was not entitled to continued LTD benefits."[5] Consequently, the Sixth Circuit admonished that discovery would provide "a better feel for the weight to accord this conflict of interest." 409 F.3d at 293 n.2. In direct conflict, the Seventh Circuit has given warrant to ERISA plan administrators to issue unchallengeable *ipse dixit* conclusions.

The split between the circuits creates a huge disuniformity in claims determinations under federal law. The ruling in *Herzberger v. Standard Ins. Co., supra.* pointed out, "It is highly desirable to have a uniform national rule [in ERISA cases]. Many employers have branches in more than one state and transfer employees from state to state with some frequency." 327 F.3d at 330. That observation highlights the necessity for review of this matter. Given the societal importance of employee benefits, the lenient approach to ERISA claims prescribed by the Seventh Circuit betrays the statute's intent to protect "the interests of participants in employee benefit plans...by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the

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[5] This Court, too, expressed concern in *Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 832 (2003) that "physicians repeatedly retained by benefits plans may have an incentive to make a finding of 'not disabled' in order to save their employers['] money and preserve their own consulting arrangements." (citation omitted).

Federal courts" (29 U.S.C. § 1001(b)) and must therefore be overturned.

Conclusion

For all of these reasons, Petitioner, William Davis, prays that this Court issue a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit.

Respectfully submitted,

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APPENDIX

IN THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

WILLIAM C. DAVIS, Plaintiff-Appellant, Cross-Appellee,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA, and REGAL-BELOIT CORPORATION LONG TERM DISABILITY PLAN, Defendants-Appellees, Cross-Appellants.

Nos. 05-2001 & 05-2165

444 F.3d 569

April 5, 2006, Decided

COUNSEL: For WILLIAM C. DAVIS, Plaintiff: Mark D. Debofsky, DALEY DEBOFSKY & BRYANT, Chicago, IL USA.

For UNUM LIFE INSURANCE COMPANY OF AMERICA, REGAL-BELOIT CORPORATION LONG TERM DISABILITY PLAN, Defendants: Michael J. Smith, Attorney at Law, Chicago, IL; Steven R. McMannon, W. Sebastian von Schleicher, MICHAEL J. SMITH & ASSOCIATES , Chicago, IL USA.

[*571] MANION, *Circuit Judge.* While working at Regal-Beloit Corporation, William Davis participated in the company's long-term disability plan, which is administered by Unum Life Insurance Company of America. After Regal-Beloit fired Davis, he sought benefits under the plan. Unum awarded Davis benefits for a mental disability but denied benefits for a physical disability. Davis sued. The district court denied summary judgment to Unum and the plan and partially granted summary judgment to Davis, remanding the matter for further administrative proceedings. Dissatisfied with his partial victory, Davis appealed. Unum and the plan then cross-appealed. Concluding that the district court misapplied the governing arbitrary-and-capricious standard, we reverse and remand, with instructions for the district court to enter judgment in favor of Unum and the plan.

I.

Regal-Beloit Corporation, an industrial machinery manufacturer, hired William Davis as a regional sales manager in February 1999. In January 2000, Regal-Beloit terminated him due to poor job performance. He was fifty-five at the time. During his brief term, Davis participated in the Regal-Beloit Corporation Long Term Disability Plan ("the plan"). The plan's administrator is Unum Life Insurance Company of America.

Under this plan, the maximum period for which a claimant can receive disability benefits varies based upon a number of factors, including whether the disability is physical or mental in nature. Generally, for physical disabilities arising before age sixty, benefit payments continue until the [*572] claimant turns sixty-five. To reach that maximum, the claimant must meet the plan's definition of "disabled" throughout the period. During the first twenty-four months of benefit payments, the term disabled means that a sickness or injury limits the claimant's performance of his "regular occupation." After twenty-four months of

payments, however, the standard becomes more difficult for the claimant to meet. The plan then defines disabled as being "unable to perform the duties of any gainful occupation for which [the claimant is] reason-ably fitted by education, training or experience." Further, separate from these provisions, there is a different time limitation for "disabilities due to mental illness." These benefits are capped at twenty-four months.

After Davis's termination, he searched for new positions and landed several interviews. Nevertheless, in July 2000, some six months after leaving Regal-Beloit, Davis remained unemployed and submitted a disability claim under the plan. On the initial form, Davis claimed to be disabled due to severe depression, memory loss, joint pain, and a stroke. He further stated that his condition prevented him from driving, lifting, and walking.

In a follow-up telephone interview, nonetheless, Davis stated that he was not restricted or limited as the result of any physical ailment; rather, he said the only reason that he was unable to work was his mental condition. According to Davis, he could not work because of depression, mood swings, forgetfulness, an inability to concentrate, and an inability to perform multiple tasks at the same time. Davis said he was homebound, adding that he did not drive at all, not even to the local market. Surveillance evidence obtained less than a month after this interview, however, showed Davis driving vehicles, refueling a vehicle, and engaging in routine outdoor chores.

Davis's doctors backed up his claims of a disabling mental illness. According to Davis's attending physician and internist, Alan Reich, M.D., the primary diagnosis was major depression. On the initial form submitted with Davis's claim, Dr. Reich listed the symptoms as indecisiveness, forgetfulness, and difficulty concentrating. Dr. Reich also noted that Davis had no cardiac limitations but had some

back and hip pain. This summary from Dr. Reich came after several other doctors had examined Davis in 2000. These doctors largely gave Davis a clean bill of physical health, but some noted psychiatric problems. For instance, Davis's urologist, Gordon Gluckman, M.D., found no recurrence of Davis's 1992 bout with prostate cancer and said Davis was "doing well." Further, Davis's neurologist, Barry Levy, M.D., in conjunction with a psychologist, Joshua Barras, Ph.D., found that depression was the source of Davis's problems and recommended psychiatric treatment. It is worth noting that, according to Dr. Levy, Davis was "very unhappy" with Drs. Levy's and Barras's opinions. Further, while Davis's disability claim was pending, Davis believed that he had a stroke, but Drs. Reich and Levy had reasons to question that belief. Particularly, Dr. Levy, in discussing the "suspected stroke," stated that "nonphysiologic features are present and suggest a psychogenic component." In other words, Davis's problem was not physical but mental.

For its part, Unum responded to the claim by consulting Robert Buchanan, M.D., a psychiatrist who worked at Unum--i.e., an "in-house doctor." The importance of this phrase will become apparent below. After reviewing Davis's medical file, Dr. Buchanan generally concurred with the findings of Davis's doctors, stating [*573] that Davis had "significant impairment from depression." In December 2000, Unum then approved Davis's disability claim pursuant to the plan's mental disability coverage. Unum paid Davis benefits retroactive to July 2000 and continued to pay him benefits until Davis reached the plan's twenty-four month limitation for mental disability benefits in July 2002.

Meanwhile, Davis began seeing a new primary doctor in February 2001, Michael Raymond, M.D. Dr. Raymond, an internist, immediately keyed in on Davis's physical complaints, including problems walking and standing. Dr. Raymond also referred Davis to a new neurologist, Steven

Meyers, M.D. Dr. Meyers found that Davis "cannot stand or walk for any distance" and concluded that Davis was "permanently disabled" due to lumbar spinal stenosis (a narrowing of the spinal canal in the lower back) and the aftereffects of childhood polio. However, according to Dr. Meyers, diagnostic testing revealed that Davis did not actually have a condition known as post-polio syndrome (progressive muscle weakness, muscle and joint pain, fatigue, etc.).

In May 2001, Davis then supplemented his existing file at Unum with the opinions of Drs. Raymond and Meyers. Davis thus began a sustained effort to obtain the more generous (i.e., longer lasting) physical disability benefits under the plan. Unum then had an orthopedic surgeon, Joseph Thomas, M.D., and an internist, Steven Feagin, M.D., review Davis's updated file. Both worked in-house at Unum. Based upon their assessments of the medical evidence, Unum notified Davis in December 2001 that his eligibility remained unchanged and that his benefits were still due to expire in July 2002.

Davis then retained counsel and submitted more information from Dr. Raymond related to spinal stenosis and other physical ailments. Despite Dr. Meyers ruling out post-polio syndrome, Dr. Raymond's papers still listed post-polio syndrome as a reason to support Davis's disability claim. Dr. Raymond further concluded Davis should be restricted from walking, lifting, bending, carrying, and climbing. It is noteworthy, however, that in this submission, Dr. Raymond stated that Davis had no functional limitations as the result of a cardiac condition.

On Unum's behalf, Dr. Thomas reviewed the new data and found that it supported a diagnosis of spinal stenosis. However, Dr. Thomas concluded that, although Davis could not stand or walk for prolonged periods, he was still able to perform sedentary work. George Fluter, M.D., a doctor of

physical medicine and rehabilitation at Unum, concurred, stating that Davis was not precluded from sedentary activities. Dr. Feagin also revisited the file and found no limitations based upon Davis's diabetes, hypertension, sleep apnea, cardiac condition, and other physical complaints, all of which were successfully treated or being treated. Additionally, according to David Goldsmith, Ph.D., a clinical psychologist at Unum, Davis's depressive disorder remained and his file indicated that Davis's "perceived" cognitive problems were only psychiatric in nature. Finally, Kelly Marsiano, M.Ed., a vocational rehabilitation specialist at Unum, identified several sedentary occupations that Davis could, in light of his physical capacity, educational background (two years of college), and employment history, perform. Unum then determined that Davis failed to meet the standard for physical disability benefits beyond twenty-four months--that is, he was not unable to perform the duties of any gainful occupation for which he was reasonably fitted. Unum thus denied his physical disability claim in December 2002.

[*574] Davis appealed, supplementing his claim with a letter from Dr. Raymond. In the letter, Dr. Raymond opined that Davis was incapable of active employment, not even a sedentary position. To this end, Dr. Raymond added carpal tunnel syndrome (previously unmentioned) to Davis's growing list of physical complaints, and, despite earlier findings in the record, Dr. Raymond's list surprisingly still included prostate cancer, post-polio syndrome, and coronary artery disease. According to Dr. Raymond, it was "difficult, if not impossible, for Mr. Davis to sit, stand or walk for any prolonged timeframes [sic]." Dr. Raymond also cited to a hypoglycemic episode (decrease of blood sugar) related to Davis's diabetes, which necessitated hospitalization in February 2003. Dr. Raymond, however, did not attach any new medical data to support the assertions in his letter. Dr. Fluter reviewed the letter, noting the obvious absence of

supporting documentation, and consequently held to his opinion that Davis could engage in sedentary work. Unum then affirmed its denial but offered Davis the opportunity to submit additional records.

Davis then supplied Unum with the hospital records of his hypoglycemic attack. The hospital records revealed that, the evening before the incident, Davis forgot to take his insulin at the scheduled time. In the morning, he then took two full doses of insulin. In addition, he did not eat breakfast. Dr. Fluter found that this occurrence of hypoglycemia was associated with the confluence of these missteps. Dr. Fluter concluded: "It would be unlikely for [Davis] to experience significant hypoglycemia with attention to proper dosing and administration of his diabetic treatment medications and to proper dietary management. This occurrence would not preclude performance of sedentary level activities." With that, the administrative case was closed. Unum issued its final decision, upholding its denial of physical disability benefits, in August 2003.

Within days, Davis sued Unum and the plan. The suit, brought under the Employee Retirement Income Security Act ("ERISA"), alleged wrongful denial of benefits pursuant to *29 U.S.C. § 1132(a)(1)(B)*. The parties filed cross-motions for summary judgment. The district court denied Unum and the plan summary judgment and partially granted Davis summary judgment. The district court faulted Unum for using only in-house doctors who perform "a mere paper review" of Davis's claims and who did not explain their conclusions to the district court's satisfaction. The district court, nevertheless, did not order Unum to award Davis physical disability benefits. Rather, the district court remanded the case back for Unum to correct the deficiencies identified by the district court in its opinion.[1] Displeased,

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[1] Although the district court remanded the case for further administrative proceedings, the district court did not reserve an opportunity to hear the

Davis appealed, seeking an outright reversal of Unum's denial and a full award of physical disability benefits. Unum and the plan then cross-appealed, contesting the district court's denial of summary judgment.

II.

Our review of the district court's summary judgment decisions is de novo. *See Sisto v. Ameritech Sickness & Accident Disability Benefit Plan, 429 F.3d 698, 700* [*575] *(7th Cir. 2005).* Before addressing the denial of Davis's claim, we first turn to the standard under which that denial should be reviewed.

A.

When, as here, the terms of an employee benefit plan afford the plan administrator broad discretion to interpret the plan and determine benefit eligibility, judicial re-view of the administrator's decision to deny benefits is limited to the arbitrary-and-capricious standard. *See id.* The district court ostensibly applied this deferential standard, but Davis challenges its applicability in this case. He, however, does not dispute the plan's language. Rather, he contends that, due to a conflict of interest, Unum was biased against him and should not be afforded any deference. This is a difficult road for Davis because the existence of potential bias, a potential conflict, is not enough to dislodge our ordinary arbitrary-and-capricious review. *See Dougherty v. Ind. Bell Tel. Co., F.3d , 440 F.3d 910, 2006 U.S. App. LEXIS 6391, 2006 WL 647719, at *5 (7th Cir. Mar. 16, 2006); Rud v. Liberty Life Assur. Co. of Boston, 438 F.3d 772, 777 (7th Cir. 2006); Mers v. Marriott Int'l Group Accidental Death &*

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results of those proceedings or otherwise postpone its final decision of the suit. Thus, for purposes of *28 U.S.C. § 1291*, the district court terminated the suit, and we have jurisdiction to hear this appeal. *See Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan, 195 F.3d 975, 979 (7th Cir. 1999).*

Dismemberment Plan, 144 F.3d 1014, 1020 (7th Cir. 1998). We presume neutrality "unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." *Kobs v. United Wis. Ins. Co., 400 F.3d 1036, 1039 (7th Cir. 2005)* (quoting *Mers, 144 F.3d at 1020*).

The source of Davis's argument is Unum's in-house doctors. However, whether a doctor is in-house or not is an irrelevant distinction in this context. To start, plan administrators have a duty to all plan participants and beneficiaries to investigate claims and make sure to avoid paying benefits to claimants who are not entitled to receive them. *See Dougherty, 2006 U.S. App. LEXIS 6391, 2006 WL 647719, at *6; Barnhart v. Unum Life Ins. Co. of Am., 179 F.3d 583, 589 (8th Cir. 1999).* Further, an administrator's decision to "seek[] independent expert advice is evidence of a thorough investigation." *Hightshue v. AIG Life Ins. Co., 135 F.3d 1144, 1148 (7th Cir. 1998).* When an administrator, like Unum here, opts to investigate a claim by obtaining an expert medical opinion--independent of its own lay opinion and that of the claimant's doctors--the administrator is going to pay a doctor one way or another. *See Wallace v. Reliance Standard Life Ins. Co., 318 F.3d 723, 724 (7th Cir. 2003).* Thus, whether the administrator retains in-house doctors (arguably reducing overhead costs for the benefit of the plan's participants and beneficiaries) or pays for freelance doctors makes no difference in this conflict analysis. Paying for a legitimate and valuable service in order to evaluate a claim thoroughly does not create a review-altering conflict.

Had Unum given its doctors some specific stake in the outcome of Davis's case, such as paying the doctors more if Davis's claim were denied, then Davis would have an argument; however, Davis has not shown that the doctors in this case had any specific incentive to de-rail his claim. *See Leipzig v. AIG Life Ins. Co., 362 F.3d 406, 409 (7th Cir.*

2004); *Perlman, 195 F.3d at 981*. Moreover, were there any legitimate doubts about the objectivity of Unum's in-house doctors in general, they would be dispelled by the actions of Dr. Buchanan, an Unum in-house doctor whose assessment, favorable to Davis, led to Unum approving mental disability benefits in the early stages of this case. In his argument here, Davis merely theorizes that in-house doctors have an inherent conflict in every case, including his. Such a theoretical argument is not enough to alter or otherwise diminish the customary arbitrary-and-capricious [*576] standard. *See Mers, 144 F.3d at 1020*; *see also Rud, 438 F.3d at 777* (claimant must "demonstrate the existence of a real and not merely notional conflict of interest"); *Kobs, 400 F.3d at 1039*; *Ruiz v. Cont'l Cas. Co., 400 F.3d 986, 991 n.1 (7th Cir. 2005)*.

B.

Under this standard, then, we will uphold Unum's denial of benefits so long as that decision has "rational support in the record." *Leipzig, 362 F.3d at 409*. "'Questions of judgment are left to the plan administrator,' and 'it is not our function to decide whether we would reach the same conclusion' as the administrator." *Sisto, 429 F.3d at 701* (quoting *Trombetta v. Cragin Fed. Bank for Sav. Employee Stock Ownership Plan, 102 F.3d 1435, 1438 (7th Cir. 1996)*; *Tegtmeier v. Midw. Operating Eng'rs Pension Trust Fund, 390 F.3d 1040, 1045 (7th Cir. 2004))*. Put simply, an administrator's decision will not be overturned unless it is "downright unreason-able." *Sisto, 429 F.3d at 700* (quoting *Tegtmeier, 390 F.3d at 1045*).

The question before us, then, is whether there is rational support in the record for Unum's determination that Davis was not disabled to the extent that he was unable to perform the duties of any gainful occupation for which he was reasonably fitted. Based upon the extensive record, summarized in our background section above, we can easily

answer this question in the affirmative. The expert opinions of Drs. Thomas, Feagin, Fluter, and Goldsmith adequately established that Davis could perform sedentary activities, and the vocational specialist identified several sedentary jobs for Davis. That is rational support. This evidence makes it "possible" for Unum "to offer a reasoned explanation" for its decision to deny benefits, and, under the arbitrary-and-capricious standard, we must respect Unum's judgment. *Semien v. Life Ins. Co. of N. Am., 436 F.3d 805, 812 (7th Cir. 2006)* (quoting *Trombetta, 102 F.3d at 1438*); *see also Dougherty, 2006 U.S. App. LEXIS 6391, 2006 WL 647719, at *7*; *Kobs, 400 F.3d at 1040*; *Leipzig, 362 F.3d at 409*.

Nevertheless, Davis argues, and the district court ruled, that Unum should not rely on this evidence for a variety of reasons, each of which we reject. Primarily, the district court (in a vein similar to that of Davis's conflict-of-interest argument above) penalized Unum for relying on in-house doctors, implying that in-house doctors inherently lack objectivity. However, again, Unum's in-house doctors were every bit as capable as outside doctors to evaluate the medical information in the file and provide independent expert medical opinions. The singular fact of working in-house does not disqualify a doctor from rendering an independent opinion any more than does paying an outside doctor to do the same, and neither the district court nor Davis go so far as to suggest that Unum could not hire a doctor to check the veracity and genuineness of Davis's claim and his doctors' opinions. Nor could they. *See Dougherty, 2006 U.S. App. LEXIS 6391, 2006 WL 647719, at *6*; *Leipzig, 362 F.3d at 409*; *Barnhart, 179 F.3d at 589*; *cf. Gaither v. Aetna Life Ins. Co., 394 F.3d 792, 807 (10th Cir. 2004)* ("fiduciary has a duty to protect the plan's assets against spurious claims"). Further-more, to the extent that the district court would have preferred that Unum supplement and verify its doctors' opinions with that of an outside doctor, the district court went beyond the bounds of arbitrary-and-capricious review.

Such questions of judgment and management are to be left to the administrator in this situation. The judicial task here is not to determine if the [*577] administrator's decision is correct, but only if it is reasonable.

The district court and Davis also fault Unum for relying on "a mere paper review," lamenting the fact that Unum's doctors did not personally examine Davis or speak with his doctors. However, neither the district court nor Davis has cited, and our research has not disclosed, any authority that generally prohibits the commonplace practice of doctors arriving at professional opinions after reviewing medical files. In such file reviews, doctors are fully able to evaluate medical information, balance the objective data against the subjective opinions of the treating physicians, and render an expert opinion without direct consultation. It is reasonable, therefore, for an administrator to rely on its doctors' assessments of the file and to save the plan the financial burden of conducting repetitive tests and examinations. *See Dougherty, 2006 U.S. App. LEXIS 6391, 2006 WL 647719, at *5* (reasonable for administrator to take fair-minded actions aimed at conserving plan assets for the benefit of all participants and beneficiaries).

This was not a situation moreover, in which the administrator's doctors were completely at odds with the claimant's doctors and the medical evidence. For example, Unum's Dr. Feagin found that the results of medical testing indicated that Davis did not have post-polio syndrome. While Davis's Dr. Raymond clung to an opposite conclusion, Dr. Feagin's view was in line with the clinical findings of Dr. Meyers, Davis's second neurologist. Similarly, Davis's first neurologist, Dr. Levy, attributed Davis's perceived physical ailments to his psychiatric condition, and Dr. Reich, Davis's first treating physician, largely indicated that Davis was mentally disabled. The consensus view of Unum's doctors that Davis was not physically incapable of performing

sedentary activities is not inconsistent with the views of Davis's first set of doctors (with whom Davis expressed dissatisfaction and replaced).

Interestingly, Dr. Raymond, who is the focal point of Davis's case, never took account of Dr. Levy's conclusion that psychiatric problems were the source of Davis's physical symptoms. Such an omission, not lost on Unum, weakens Dr. Raymond's reliability. *See Shyman v. Unum Life Ins. Co., 427 F.3d 452, 456 (7th Cir. 2005).* There are additional reasons in the record to question the reliability of Dr. Raymond. For instance, in 2001 and 2002, Dr. Raymond's noted limitations for Davis were standing, walking, lifting, bending, carrying, and climbing, and Dr. Thomas at Unum agreed with Dr. Raymond in this regard, concluding that Davis could not walk or stand for pro-longed periods. Nonetheless, after Dr. Thomas also stated that Davis could perform sedentary activities, Dr. Raymond then, in a 2003 letter, conveniently added sitting to Davis's list of limitations. Dr. Raymond's letter, in a similar after-the-fact approach, attempted to undermine the notion that Davis could perform sedentary activities by introducing carpal tunnel syndrome to Davis's growing list of complaints; however, Dr. Raymond provided nothing to substantiate this newfound ailment. Dr. Raymond further cited Davis's hypoglycemic episode as a source of disability. Nonetheless, Dr. Raymond ignored the fact, cogently identified by Unum's Dr. Fluter, that, if Davis adhered to his medication schedule and a proper diet, Davis would avoid such attacks. Moreover, Dr. Raymond continued to list prostate cancer as a factor contributing to Davis's disability, yet Dr. Raymond made no attempt to reconcile the fact that Davis's urologist, Dr. Gluckman, found that Davis's 1992 encounter with prostate cancer was successfully treated [*578] without recurrence. Further, Dr. Raymond's views on Davis's cardiac health were also inexplicably inconsistent. In 2001, Davis had a successful angioplasty to relieve a partially blocked

artery, and, in 2002, Dr. Raymond affirmatively designated that Davis had no functional limitations on account of his cardiac condition. However, in 2003, without new data in the record, Dr. Raymond changed his position, listing coronary artery disease as a reason to consider Davis disabled.

In this light, these examples and others in the record show Dr. Raymond more as an advocate than a doctor rendering objective opinions. *Cf. Leipzig, 362 F.3d at 409* ("Most of the time, physicians accept at face value what patients tell them about their symptoms; but [administrators] must consider the possibility that applicants are exaggerating in an effort to win benefits (or are sincere hypochondriacs not at serious medical risk)."). To a lesser extent, the record reveals similar questions about certain conclusions from Dr. Meyers. Suffice it to say that Davis presented a medical file of questionable reliability. It is not surprising, therefore, that Unum's doctors arrived at some opposite conclusions from those of Drs. Raymond and Meyers. What is more, given the vagaries and contradictions apparent on the face of Davis's claim, it was reasonable for Unum to rely on its doctors' file reviews in denying Davis's claim. *See Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834, 123 S. Ct. 1965, 155 L. Ed. 2d 1034 (2003)* ("Plan administrators, of course, may not arbitrarily refuse to credit a claimant's *reliable* evidence, including the opinions of a treating physician. But, we hold, courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." (emphasis added)). Furthermore, reaching a decision amid such conflicting medical evidence is a question of judgment that should be left to Unum under the arbitrary-and-capricious standard. *See id.*; *Ruiz, 400 F.3d at 992*. Once again, the objective here is not to determine if Unum's decision is correct, but only if it is reasonable.

The final point to address is the explanations supporting the denial, which the district court and Davis conclude are insufficient. The dispute here is not about the adequacy of Unum's explanations, as the plan administrator, for the denial. Nor could it be. Unum's denial letters to Davis sufficiently detailed Unum's reasoning. *See Herman v. Cent. States, Se. & Sw. Areas Pension Fund, 423 F.3d 684, 692-93 (7th Cir. 2005)* ("This court will not substitute the conclusion it would have reached for the decision of the administrator, as long as the administrator makes an informed judgment and articulates an explanation for it that is satisfactory in light of the relevant facts." (quotation omitted)). Nevertheless, the district court and Davis take issue with the underlying explanations from Unum's doctors, criticizing the brevity of their medical writings. However, contrary to the district court's view, there is nothing in ERISA or our precedent requiring doctors to write like lawyers or plan administrators. Were we to arrive at such a decision today, we would unnecessarily and unwisely drive up the administrative costs of benefit plans, the negative affects of which would ultimately be borne by workers. ERISA counsels a different approach. *See Gilbertson v. Allied Signal, Inc., 328 F.3d 625, 635 (10th Cir. 2003)* ("congressional purpose in enacting ERISA was 'not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage [*579] employers from offering welfare benefit plans' " (quoting *Varity Corp. v. Howe, 516 U.S. 489, 497, 116 S. Ct. 1065, 134 L. Ed. 2d 130 (1996))*); *Martin v. Ark. Blue Cross & Blue Shield, 299 F.3d 966, 972 (8th Cir. 2002)* (en banc).

It is enough, in situations such as this, for the doctors to review the file and render a professional, medical opinion. The record here unequivocally demonstrates that Unum's doctors reviewed the data supplied by Davis. The district court admitted as much in stating, "In their re-view of the file, Unum's in-house doctors did discuss [Davis's] medical

testing and (implicitly) suggested that the objective results did not indicate that [Davis] cannot perform sedentary work." The Unum doctors' conclusions, however, were not simply "implicit."[2] For example, there was nothing implicit or vague about Dr. Fluter's afore-mentioned conclusion regarding Davis's hypoglycemia. It was explicit and compelling. Further, to the extent that other conclusions were summary, we again see no grounds here for mandating that doctors draft lengthy, lawyer-like opinions.

Bottom line, the record contains rational support for Unum's denial of physical disability benefits. In concluding otherwise--and penalizing Unum for relying on in-house doctors who reviewed the file and gave doctor-like explanations for their conclusions--the district court went beyond the bounds of arbitrary-and-capricious review. On this record, it is not "downright unreasonable" to find that Davis was not unable to perform the duties of any gainful occupation for which he was reasonably fitted. We will thus uphold Unum's denial of long-term disability benefits under the arbitrary-and-capricious standard. Further, because Unum and the plan are entitled to summary judgment, there is no need for us to discuss Davis's challenge to the district court's remand for further administrative proceedings.

III.

The correct standard to review Unum's denial of benefits in this case is the arbitrary-and-capricious standard. There is no evidence of conflict or bias that would necessitate a less deferential level of review. Furthermore, as with Unum's grant of mental disability benefits (which lasted twenty-four months), Unum's denial of long-term physical disability

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[2] Several of Unum's in-house doctors submitted detailed recitations of their medical evaluations rather than forms with checked boxes and cryptic comments.

benefits has rational support in the record. Therefore, under the arbitrary-and-capricious standard, we will not disturb Unum's decision. Accordingly, the judgment of the district court is REVERSED, and the case is REMANDED with instructions for the district court to enter judgment in favor of Unum and the plan.

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS EASTERN DIVISION

WILLIAM C. DAVIS, Plaintiff,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA, and REGAL-BELOIT CORPORATION LONG TERM DISABILITY PLAN, Defendants.

03 C 6362

March 31, 2005, Decided
March 31, 2005, Docketed

MEMORANDUM OPINION AND ORDER

REBECCA R. PALLMEYER, Judge:

Plaintiff William Davis was an employee of the Regal-Beloit Corporation from February 4, 1999 until his termination in January 28, 2000. While employed by Regal-Beloit, Plaintiff participated in the Regal-Beloit Corporation Long-Term Disability Plan. In August 2000, after his termination, Plaintiff submitted a claim for total disability benefits based upon a diagnosis of major depression. The plan's underwriter, Defendant Unum Life Insurance Company of American ("Unum"), approved the claim,

subject to the plan's 24-month limitation for coverage of claims based on mental illness. In June 2001, approximately six months before his disability coverage was scheduled to expire, Plaintiff submitted an additional claim based on a number of alleged physical disabilities. Unum declined coverage after investigating the new claim, and subsequently denied a number of appeals brought by Plaintiff. On July 25, 2002, Unum cancelled Plaintiff's disability coverage pursuant to the 24-month limitation. Plaintiff now brings a claim seeking restoration of disability income benefit payments under § 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974, *29 U.S.C. § 1132(a)(1)(B)* ("ERISA"). Defendants have moved for summary judgment and Plaintiff has filed a cross-motion for summary judgment pursuant to *Federal Rule of Civil Procedure 56* and, in the alternative, requests findings of fact and conclusions of law pursuant to *Federal Rule of Civil Procedure 52*. For the reasons set forth below, Defendants' motion is denied, and Plaintiff's motion is granted. The case is remanded to the Unum Plan administrator for further review.

FACTUAL BACKGROUND

This action stems from a long-term disability insurance policy (the "Unum Policy") established and funded by Plaintiff's former employer, the Regal-Beloit Corporation ("Regal Beloit"), and administered by Unum.

I. Relevant Policy Provisions

At issue is whether Plaintiff suffers from a physical disability under the Unum Policy, and therefore entitled to continued disability benefits. Under the Unum Policy, a claimant qualifies as disabled "when Unum determines that" the claimant is "limited from performing the material and substantial duties of [his] regular occupation due to [his] sickness or injury [causing a] 20% of more loss in [his] indexed monthly earnings." (Defendants' Local Rule 56.1(a)

Statement, hereinafter "Defs.' 56.1(a)," P 9; Administrative Record, hereinafter R., at UACL00458.) The policy provides that "disabilities due to mental illness have a limited pay period up to 24 months." (Defs.' 56.1(a) P 10; R. at UACL00447.) Moreover, regardless of the type of disability, in order to receive benefits for more than 24 months, a claimant must show that he is "unable to perform the duties of any *gainful occupation* for which [he is] reasonable fitted by education, training or experience." (*Id.*) The Policy's Certificate of Coverage grants Unum "discretionary authority to determine [the claimant's] eligibility for benefits and [*4] to interpret the terms and provisions of the policy." (Defs.' 56.1(a) P 8; R. at UACL00462.)

II. Claim for Long-Term Disability Benefits

Plaintiff has suffered from a variety of health problems throughout his life. He survived a bout with polio at age seven, which left him with atrophy of his left calf muscle. (R. at UACL00088.) He has a history of elevated cholesterol, hypertension, and diabetes. (R. at UACL00090.) In addition, Plaintiff has long suffered from recurring episodes of severe depression, for which he takes a variety of prescription medications. (*Id.*)

Plaintiff was employed as a regional sales manager by the Regal-Beloit Corporation in Chicago from approximately February 4, 1999 until January 28, 2000. (Defs.' 56.1(a) PP 4, 11.) On January 12, 2000, Plaintiff was admitted to Holy Family Medical Center for evaluation and management of a possible transient ischemic attack (stroke). (Plaintiff's Local 56.1(a) Statement, hereinafter "Pl.'s 56.1(a)," P 69.) Upon Plaintiff's admission, the treating physician, Dr. Alan Reich, noted that Plaintiff was unable to communicate, comprehend words, or do basic arithmetic. (*Id.*) After examining Plaintiff, Dr. Reich expressed his opinion that Plaintiff had suffered a

transient ischemic attack and not a stress-related disorder. (*Id.* P 76.)

Plaintiff's employment at Regal-Beloit was terminated on approximately January 28, 2000. Defendants maintain that Plaintiff's employment was terminated due to poor performance. (Defendants' Response to Plaintiff's Local 56.1(a) Statement PP 7, 23; R. at UACL00023.) In an "Education and Employment History" form submitted to Unum as part of his claim, Plaintiff conceded that he "was let go because of memory and decisionmaking" problems, (Education and Employment History form, R. at UACL000269), but he asserts in this litigation that he was terminated "due to arthritis pain, severe depression, loss of memory, and other medical conditions subsequent to suffering a stroke." (Pl.'s 56.1(a) P 7; Long Term Disability Claim: Employee's Statement, R. at UACL00019.)

On July 10, 2000, after the Unum Policy's 180-day elimination period had passed, Plaintiff filed a claim for long-term disability benefits under the Unum Policy, alleging that he had been disabled since January 28, 2000. (Pl.'s 56.1(a) P 14.) Plaintiff claimed that he was eligible for long-term benefits because he suffered "arthritis pain in the joints, severe depression, loss of memory, and stroke." (Pl.'s Res. to Defs.' 56.1(a) P 17; Long Term Disability Claim: Employee's Statement, R. at UACL00019.) As a result of these ailments, Plaintiff claimed that he was unable to lift, drive, or walk. (R. at UACL00019.) In support of his application, Plaintiff submitted a statement by Dr. Alan M. Reich concluding that he suffers from "major depression." (Defs.' 56.1(a) P 17; Long Term Disability Claim: Physicians Statement, R. at UACL 00017.) Dr. Reich's statement also listed "weakness and atrophy of the left calf causing back and hip pain" as a secondary condition contributing to his disability. (Pl.'s 56.1(a) P 16; Long Term Disability Claim: Physician's Statement, R. at UACL00017.)

At Unum's request, Plaintiff provided the names of eight treating physicians and a list of medications prescribed for the treatment of diabetes, high-blood pressure, osteoarthritis, elevated cholesterol, and depression. (Pl.'s 56.1(a) PP 35-36.) Unum subsequently obtained medical records from Plaintiff's many health care providers. (Defs.' 56.1(a) PP 25-27.) These records revealed that Plaintiff had suffered from recurring incidents of major depression dating back to the early 1990s, and had been hospitalized with suicidal ideation in 1998. (*Id.* P 19.) In March and April 2000, Dr. Joshua Barnes performed a series of three neurophysical evaluations on Plaintiff, concluding that he suffered from major depression and depressive pseudodementia. (*Id.* PP 19-20.) Another neurologist, Dr. Barry Levy, examined Plaintiff and found that he suffered from "periodic limb disorder" which appeared with sleep apnea. (Letter from Berry Levy to Alan Reich, Appendix to Defs.' 56.1(1), hereinafter R. at UACL00009.) In a letter dated May 23, 2000, Dr. Levy concluded, however, that "depression is causing his symptoms," and recommended that Plaintiff see a psychiatrist. (*Id.* P 21; Letter from Barry Levy to Alan Reich, R. at UACL00009.)

On June 29, 2000, Dr. Keith Poteet, a chiropractor, treated Plaintiff for chronic right shoulder, lower back, and left hip pain. (R. at UACL00211-00209.) Dr. Poteet concluded that Plaintiff experiences pain after standing for 90 seconds, and that after three to five minutes the pain becomes unbearable and Plaintiff must sit down. (*Id.* at UACL00210.) He also concluded that Plaintiff experiences pain when sitting for extended periods of time and that he must "move or readjust" after sitting for ten minutes. (*Id.*)

As part of its initial investigation, Unum requested and received a job analysis from Plaintiff's employer. This analysis indicated that, as a sales manager for Regal-Beloit, Plaintiff was responsible for monitoring the performance of

the sales department, answering sales questions, and working directly with customers. (Long Term Disability Claim: Job Analysis, R. at UACL 31-30.) The job involved alternately standing and sitting, although it required Plaintiff to travel by automobile or airplane up to 20% of the time. (*Id.*) According to the job analysis, Plaintiff was never required to stoop, kneel, reach overhead, or climb stairs, and only "rarely" required to lift or carry objects. (*Id.*)

In light of this job analysis, Unum placed Plaintiff under surveillance during a three-day period in September 2000. (Defs.' 56.1(a) P 29.) On September 27, 2000, investigators videotaped Plaintiff driving to and from the gas station, filling his car with gasoline, and carrying his garbage can and recycling bin into the house. (Pl.'s Res P 30; Investigation Report, R. at UACL00187.) During these activities, Plaintiff was observed "walking, standing, sitting, lifting, carrying, pushing, bending over a 90 degree angle, entering and exiting a vehicle, and driving." (Defs.' 56.1(a) P 30; Investigation Report, R. at UACL00187.) On September 28, Davis was observed driving his car to and from a gas station, and retrieving his mail. (*Id.* P 30, Investigation Report, R. at UACL00184-00183.) The investigators did not witness any activity on the third day. (Investigation Report, R. at UACL00183-00182.)

On December 14, 2000, Dr. Robert Buchanan, a psychiatric consultant for Unum, conducted a file review and concluded that "there is an indication of significant impairment from depression particularly as it would relate to having the energy, memory, and cognitive ability to be a sales manager." (Defs.' 56.1(a) P 33; File Review, R. at UACL00252-251.) The following day, Unum notified Plaintiff by letter that his claim for disability benefits had been approved. (Letter from Alisha Avery to William Davis, at UACL 00258.) The letter indicated that a check in the amount of $ 10,172.44 for the period of disability from July

26, 2000 through November 25, 2000 would be enclosed under separate cover. (Defs.' 56.1(a) P 34; R. at UACL00258.) Thereafter, the letter stated that Plaintiff would receive $ 2650.00 per month (60% of his basic monthly earnings) so long as he remained eligible.[3] (*Id.*) The letter further explained that benefits were not payable during the 180-day elimination period that extended from January 28 through July 26, 2000, and that since his disability had lasted more than five months,[4] Plaintiff must apply for Social Security Disability Insurance (SSDI), with any resulting benefits being deducted from his Unum benefit.[5] (*Id.* P 15, 34.) Finally, the letter advised that Plaintiff's eligibility for benefits was capped at a maximum of 24-months because his disability was based on a mental illness. (Defs.' 56.1(a) P 36; Letter from Alisha Avery to William Davis, R. at UACL00254.)

III. Plaintiff's Second Disability Claim

On April 23, 2001, Plaintiff's psychiatrist, Dr. Elizabeth de sa Peria submitted a functional capacities evaluation and physician's statement to Unum in which she concluded that Plaintiff suffered from depression, anxiety, panic, frequent crying, and concentration and memory problems due to a major depressive disorder. (Defs.' 56.1(a) PP 40-41.) Dr. de sa Peria also listed diabetes and childhood polio as secondary conditions contributing to Plaintiff's disability. (Long Term

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[3] Plaintiff's monthly salary at Regal-Beloit was $4,416.67 (Defs.' 56.1(a)P 22.)

[4] Under the Social Security Guidelines, a claimant must be disabled for five full consecutive calender months before becoming eligible for SSDI benefits. (Letter from Social Security Administrative to William Davis, dated Nov. 12, 2000, R at UACL00265.)

[5] In a letter dated January 16, 2001, Plaintiff advised Unum that he had been awarded monthly SSDI benefits of $1,487.00 retroactive to July 2000. (Defs.' 56.1(a) P 37.) the letter does not indicate the nature of Plaintiff's disability.

Disability Claim: Physician's Statement, R. at UACL00276.) Subsequently, on May 28 and June 15, 2001, Plaintiff wrote to Unum and stated that Dr. Steven Myers and Dr. Michael Raymond had conducted examinations and concluded that he suffered from independent physical disabilities. (Pl.'s 56.1(a) P 41.) In a subsequent letter, Dr. Myers concluded:

> Mr. Davis has lumbar spinal stenosis superimposed upon his polio. He also appears to have suffered a small stroke in December 2000 with some mild residual right-sided weakness. While any one of these particular problems may not be terribly disabling, I believe the combination of the three has resulted in permanent disability. Mr. Davis cannot stand or walk for any distance and has significant lower extremity weakness. I believe that he is presently disabled from the lumbar spinal stenosis and the polio.

(R. at UACL00306.) Dr. Raymond's report is nearly illegible, but it mentions stenosis,[6] sleep apnea, and post-polio syndrome among its diagnoses. (R. at UACL00314-00312.)

Upon receipt of these letters, Unum directed Kathryn Gregory[7] and Dr. Joseph Thomas, a board-certified orthopedic surgeon employed by Unum, to review Plaintiff's medical records pertaining to his lower back pain and

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[6] Spinal stenosis is the narrowing of the spinal canal. Symptoms can include pain and difficulty walking, numbness, weakness in legs, clumsiness and frequent falling. *See* http://www.spinenet.com/stenosis.htm

[7] Defendants identify Gregory as a "orthopedic registered nurse" in their 56.1(a) statement, but fail to cite to any evidence in the record identifying her position or qualifications.

arthritis. Ms. Gregory reviewed Plaintiff's claim and medical records, and submitted a summary to Dr. Thomas for comment. In a two-paragraph memorandum dated August 13, 2001, Dr. Thomas concluded that although Plaintiff suffers from weakness and loss of reflex, he does not have a "significant impairment that would affect claimant in regards to work as a salesman or sales manager." (Defs.' 56.1(a) PP 44-45; CRS Response, R. at UACL00359.) Dr. Thomas also indicated that he believed Plaintiff's condition to be relatively stable and that rapid deterioration is not expected. (*Id.*) Dr. Thomas did not address Dr. Meyers's conclusion that Plaintiff was disabled and unable to stand or walk for any distance, nor the basis for his conclusion that Plaintiff could work as a salesman. Dr. Thomas did not examine Plaintiff, nor attempt to contact either of Plaintiff's treating physicians regarding their examinations or diagnoses.

Thereafter, Shirley Yeager[8] reviewed Plaintiff's medical records to determine whether a diagnoses of diabetes and hypertension would support restrictions and limitations on Plaintiff's ability to work. (Defs' 56.1(a) P 46; Clinical Review Request, R. at UACL00381-00379.) Yeager reviewed the diagnostic testing in the records, including an MRI of the head, CT scan of the brain, carotid dopplers, echo EKG. EEG and sleep apnea studies, and concluded that all were normal except for the sleep study and EEG.[9] The sleep study supported the need for a C-PAP,[10] which

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[8] Defendants state in their 56.1(a) statements that Yeager is a registered nurse, but there is no evidence in the record as to her position or qualifications.

[9] Obstructive sleep apnea is caused by the blockage of the airway during sleep. Untreated, it can cause high blood pressure and other cardiovascular disease, memory problems, weight gain, impotency, and headaches. *See* http://www.sleepapnea.org/.

[10] A nasal C-PAP (Continuous Positive Airway Pressure) delivers air into a sleeping person's airway through a specially designed mask or pillow. It is designed to alleviate snoring and obstructive sleep apnea. *See* http://www.entnet.org/healthinfo/snoring/cpap.cfm.

Plaintiff uses at night, and the EEG was "mildly abnormal." (*Id.*) Yeager also noted that Plaintiff was on insulin for diabetes, which appeared well controlled. (*Id.*) Finally, Ms. Yeager noted that both Dr. Levy and Dr. Reich had indicated (in 2000) that depression was causing Plaintiff's symptoms and that his medical records do not support his claimed physical disability. (*Id.*)

Dr. Steven Feagin also reviewed Plaintiff's medical records on behalf of Unum. Dr. Feagin agreed that Plaintiff's diabetes, hypertension, and cardiovascular condition do not support employment restrictions. (Defs.' 56.1(a) P 47; Physician Response, R. at UACL00378.) After noting that the electro diagnostic study showed no active denervation to suggest post-polio syndrome,[11] Dr. Feagin concluded that Plaintiff does not suffer from post-polio syndrome, but rather has stable old polio effects. (*Id.*) In support of this conclusion, he also noted that "claimant had polio [at] age seven and [had] worked with the polio defects" his entire life. (*Id.*) Dr. Feagin did not discuss Dr. Myers's and Raymond's spinal stenosis diagnosis.

On December 6, 2001, Debra Hansen, a Unum employee who holds the title of Customer Care Specialist, informed Plaintiff that his monthly benefits would cease on July 25, 2002, pursuant to the Unum Policy's 24-month benefit period limit for mental disabilities. (Letter from Debra Hansen to William Davis, dated Dec. 6, 2001, R. at UACL00387-00385.) On January 16, 2002, Plaintiff appealed Unum's decision to deny his application for continued disability benefits based on his claimed physical disabilities. (Defs.' 56.1(a) P 49.)

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[11] Post-polio syndrome is a condition that can strike polio survivors ten to forty years after recovery from their initial bout with the disease. It is characterized by a weakening of the muscles that were previously injured by the polio virus. Symptoms include "fatigue, slowly progressive muscle weakness, muscle and joint pain, and muscular atrophy." *See* http://www.ppsr.com/.

On April 18, 2002, Plaintiff's psychiatrist, Dr. Alan Miller, provided a functional capacity evaluation and mental status supplemental questionnaire in which he reported that Plaintiff "remains chronically depressed with social withdrawal, impaired concentration, impaired memory, [and] difficulty with decision making." (R. at UACL00397.) In light of these symptoms, Dr. Miller concluded that Plaintiff is "chronically disabled from his mental disorder." (*Id.*)

In a letter dated June 4, 2002, Plaintiff, through counsel, submitted additional medical records in support of his claim for benefits on the basis of a physical disability. (Pl.'s 56.1(a) P 23; Letter from Mark DeBofsky to Debra Hansen, R. at UACL00595-00593.) In addition to Dr. Miller's diagnosis, the letter highlighted Plaintiff's admission to the Rush North Shore Medical Center on September 25, 2001, after an echocardiogram reported an inferior wall abnormality. (R. at UACL00594.) During this visit, Dr. Raymond presented diagnoses of coronary artery disease, diabetes mellitus, anticardiolipin antibody syndrome, sleep apnea, spinal stenosis, and poliomyelitis. (*Id.*) In light of these ailments, Dr. Raymond concluded that Plaintiff cannot "lift, bend, carry, walk, [and] climb" and that he expected no improvement in Plaintiff's condition. (R. at UACL00591.) In addition, the letter again referenced Dr. Myers' August 2001 diagnosis of spinal stenosis. (R. at UACL00594.)

Dr. Feagin again reviewed the medical records and concluded in a single sentence that his prior conclusions remained unchanged on July 12, 2002. (*Id.* at UACL00596.) Dr. Thomas further reviewed the file on behalf of Unum in September 2002, concluding that although the diagnosis for spinal stenosis was supported, Plaintiff should be able to perform the type of position that he filled at Regal-Beloit. (*Id.* at UACL00610.) Unum denied this second claim in a letter dated December 12, 2002 on the basis that there was no "clear evidence that all of [Plaintiff's] non-psychiatric

conditions caused impairment to a degree that would preclude performance of sedentary level activities." (*Id.* at UACL00636-00633.) Again, neither doctor discussed the conclusions of Plaintiff's treating physicians that he was disabled and had difficulty walking, nor their basis for concluding otherwise.

On September 27, 2002, Dr. David Goldsmith, a clinical psychologist, reviewed the file from a psychiatrist and neurocognitive standpoint on Unum's behalf.[12] (Defs.' 56.1(a) P 55.) Dr. Goldsmith focused on suggestions that Plaintiff suffered from dementia, noting that the file contained no evidence that Plaintiff's neurocognitive functioning had been formally assessed since Dr. Levy's report in April 2000, when Dr. Barras concluded that Plaintiff's "difficulty with concentration, forgetfulness, and indecisiveness are primarily due to his mood disorder." (R. at UACL00622.) In light of this, Dr. Goldsmith decided that "suggestions that his neurocognitive problems have progressed or that the insured's mental processing is currently impaired by organic, non-psychiatric problems have not been supported with clinical evidence." (*Id.* at UACL00621.) Dr. Goldsmith concluded that a diagnosis of dementia was unsupported by Plaintiff's medical records. (*Id.*)

Unum also directed Kelly Marsiano, a vocational rehabilitation consultant, to review the file and conduct a transferable skills analysis ("TSA") based upon Plaintiff's education, training, and job experience. Ms. Marsiano limited her analysis to those positions in the "sedentary or possibly light level," and consider Dr. Thomas's conclusion

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[12] It is not clear why Unum was investigating Plaintiff's mental state or possible dementia in September 2002, as his 24-month limit on coverage for mental disability had already expired. Moreover, as Dr. Goldsmith noted, there had been no indications that Plaintiff suffered from dementia since April 2000, at which time Dr. Levy conducted the last neurocognitive assessment of Plaintiff. (R. at UACL00622.)

that "prolonged walking or standing may not be tolerated." (R. at UACL00619.) In light of Plaintiff's "strong work history" and "stabilized medical conditions," Marsiano concluded that Plaintiff would qualify for the positions of training manager, sales product manager, and plant supervisor, all of which had salaries within the definition of gainful employment under the Unum Policy."[13] (*Id.* at UACL00617.)

Subsequently, in November 2002, Dr. George Fluter, a board-certified doctor in physical medicine and rehabilitation, reviewed Plaintiff's records to assess his claimed physical disabilities. Dr. Fluter found evidence of "diffuse weakness of both lower extremities" including use of an assistive aid in walking, and mild to moderate spinal stenosis. (R. at UACL00628.) After analyzing Plaintiff's electrodiagnostic studies done in March 2001, Dr. Fluter concluded that there was no denervation[14] to suggest post-polio syndrome. (*Id.*) After reviewing Plaintiff's medical records, Dr. Fluter concluded that although Plaintiff suffers from a number of medical problems, "there does not appear to be clear evidence that all of the non-psychiatric conditions cause impairment to a degree that would preclude performance of sedentary level activities." (*Id.*) Dr. Fluter made no reference to the reports of Plaintiff's treating physicians, nor did he discuss his reasons for rejecting their conclusions that Plaintiff was disabled.

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[13] The CBA does not expressly define "gainful employment," but it does provide that after 24 months of payments, disability payments will cease if the recipient's monthly earnings exceed the gross disability payment. (R. at UACL00748.) During the first 24 months, disability payments will continue so long as the recipient's monthly earnings do not exceed 80% of his or her indexed monthly earnings. (*Id.*)

[14] Denervation is a medical term referring to loss of nerve supply. Denervation may be caused by illness (such as polio), chemicals, or physical injury. *See* http://www.talkmedical.com/medical-dictionary/3891/Denervation.

By letter dated December 12, 2002, Unum Customer Care Specialist Debra Hanson notified Plaintiff's attorney that his benefit period under the mental illness limitation expired on July 25, 2002. (R. at UACL00636.) The letter explained that after 24 months of payment, Plaintiff is no longer eligible for coverage unless Unum determines that he is unable to perform any gainful employment for which he is reasonable fitted. (*Id.*) Hanson explained that Unum representatives had evaluated his claim for continued benefits pursuant to his physical conditions, and concluded that although the diagnosis of spinal stenosis is supported, "the implication that the claimant could not perform in at least the sedentary level is not supported. Treatment should be directed toward maintaining activity, weight loss, non-steroidal medication, and possibly physical therapy on an episodic basis." (*Id.*)

IV. Appeal of Denial of Physical Disability Claim

On January 12, 2003, Plaintiff, through counsel, submitted notice of appeal of Unum's denial of benefits based on his physical disability. (Pl.'s 56.1(a) P 28; R. at 00638-00627.) In support of his appeal, Plaintiff submitted a statement from Dr. Raymond regarding his physical disabilities. In his statement, Dr. Raymond stated that Plaintiff suffers from "significant" physical disabilities, including diabetes mellitus, anticardiolipin antibody syndrome, transient ischemia attack, coronary artery disease, sleep apnea, lumbar spinal stenosis, carpal tunnel syndrome, prostate cancer, and post-polio syndrome. (Letter from Michael Raymond to Steven Jackson, dated May 19, 2003, R. at UACL00659-00658.) Dr. Raymond concluded that Plaintiff was disabled due to cumulative effect of these multiple impairments:

> As the sum total of the above conditions, I have found Mr. Davis to be significantly

> impacted on a purely physical basis. He ambulates with the assistance of a wheeled walker due to a combination of leg weakness from postpolio syndrome and pain from spinal stenosis. These conditions make it difficult, if not impossible, for Mr. Davis to sit, stand or walk for any prolonged timeframes. He experiences numbness of his hands from carpal tunnel syndrome, which would preclude an excessive amount of writing or activities involving fine manipulative abilities or repetitive type activities. He has most recently had an episode of hypoglycemia in which he was found driving on the wrong side of the street incoherent requiring acute hospitalization, this secondary to his diabetes.
>
> I have reviewed the Social Security Administration definition of work activities and under that of sedentary work I do not believe Mr. Davis to be able to complete even that, i.e., exerting up to 10 pounds of force occasionally or a negligible amount one-third to two-thirds of the time in activities such as lifting, carrying, pushing, pulling or moving objects. In sum, I do not believe that Mr. Davis is capable of active employment at this time based on the above conditions.

(*Id.*)

On July 8, 2003, Dr. Fluter reviewed Dr. Raymond's additional statement and concluded that the letter contained "no additional information" regarding Plaintiff's orthopedic and neurological status, and that the contents of the letter were "not sufficient to warrant a change in opinion" from his

November 2002 review. (R. at UACL00665.) Thereafter, in a letter dated July 9, 2003, Lead Appeals Specialist Louise Pons advised Plaintiff that Unum representatives had reviewed the additional information attached to his appeal letter and upheld the previous decision to terminate benefits after 24 months. (R. at UACL00666.)

Not to be deterred, on August 4, 2003, Plaintiff submitted additional documentation regarding hospitalization at Illinois Masonic Hospital from an episode of hypoglycemia in February 2003. (Pl.'s 56.1(a) P 31.) After receiving this information, Dr. Fluter reviewed these records on behalf of Unum. Dr. Fluter noted that the incident was possibly triggered by Plaintiff's failure to eat breakfast on the day of the episode and concluded that "it would be unlikely for the claimant to experience significant hypoglycemia with attention to proper dosing and administration of his diabetic treatment medications and to proper dietary management." (Physician Response, R. at UACL00705.) He further stated his belief that "this occurrence would not preclude performance of sedentary level activities." (*Id.*) In light of this report, Unum advised Plaintiff that his second appeal had been denied in a letter dated August 25, 2003. (Pl.'s 56.1(a) P 32; Letter from Louise Pons to William Davis, dated Aug. 25, 2003, R. at UACL00714.) The letter further advised Plaintiff that his administrative remedies had been exhausted with this second appeal. (Defs.' 56.1(a) P 67; R. at UACL00716.)

V. Procedural History

After Unum denied his final appeal, Plaintiff filed the instant action on September 9, 2003, alleging that Unum wrongfully denied his claim for disability benefits in violation of ERISA, *29 U.S.C. § 1132(a)(1)(B)*. The parties have now filed cross-motions for summary judgment.

DISCUSSION

The parties raise two issues in their respective motions for summary judgment. First, the parties dispute the applicable standard of review of Unum's denial of disability benefits. Second, the parties dispute the propriety of Unum's denial of Plaintiff's claim for continued disability benefits.

I. Summary Judgment Standard

Summary judgment shall be granted "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." *FED. R. Civ. P. 56(c)*; *Celotex Corp. v. Catrett, 477 U.S. 317, 322-23, 91 L. Ed. 2d 265, 106 S. Ct. 2548 (1986)*. A genuine issue of material fact exists where "the evidence is such that a reasonable jury could return a verdict for the nonmoving party," *Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248, 91 L. Ed. 2d 202, 106 S. Ct. 2505 (1986)*, when a court views the record and all reasonable inferences drawn from it in a light most favorable to the nonmoving party. *Id. at 255*; *Payne v. Pauley, 337 F.3d 767, 770 (7th Cir. 2003)*. "If no genuine issue of material fact exists, the sole question is whether the moving party is entitled to judgment as a matter of law." *Logan v. Commercial Union Ins. Co., 96 F.3d 971, 978 (7th Cir. 1996), citing Miranda v. Wisconsin Power & Light Co., 91 F.3d 1011, 1014 (7th Cir. 1996)*.

II. ERISA Standard of Review

Congress enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." *Black & Decker Disability Plan v. Nord, 538 U.S. 822, 830, 155 L. Ed. 2d 1034, 123 S. Ct. 1965 (2003)*; *Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989)*. *Section 1132(a)(1)(B)* allows a

participant in or beneficiary of a covered plan to sue "to recover benefits due to him under the terms of his plan." *29 U.S.C. § 1132(a)(1)(B).* Under ERISA, the standard of review for benefit determinations hinges on whether the plan administrator has been granted discretion in making the benefit determination. *Bruch, 489 U.S. at 115.* Generally, courts review benefit determinations under ERISA on a *de novo* standard. *Id.* Where a benefit plan gives the administrator discretionary authority to determine benefits eligibility, however, the decision will be reviewed under an arbitrary and capricious standard. *Id. at 111.*

When deciding whether a benefit plan confers discretion on the plan administrator, courts review the language of the plan *de novo. Ramsey v. Hercules, 77 F.3d 199, 205 (7th Cir. 1996), citing Bechtold v. Physicians Health Plan of Northern Indiana, Inc., 19 F.3d 322, 325 (7th Cir. 1994).* A grant of discretion must be clear and will not be assumed. *Herzberger v. Standard Ins. Co., 205 F.3d 327, 331 (7th Cir. 2000)* ("An ERISA plan can likewise specify that the administrator has discretion in interpreting or applying it . . . but the conferral of such discretion is not the be assumed."). In *Herzberger,* the Seventh Circuit created "safe harbor" language through which an ERISA plan will be conclusively read as granting discretion in the plan administrator. *Id. at 331.* The safe harbor language, which reads "Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them," is not mandatory. *Id.* Nevertheless, language purporting to convey discretion in the administrator must indicate with "clarity that a discretionary determination is envisaged." *Id.* The court specifically cautioned that the presumption of *de novo* review is not rebutted by language stating that "benefits will be paid only if the plan administrator determines they are due, or only if the applicant submits satisfactory proof of his entitlement to them." *Id.*

In the present case, the Unum Policy states that "when making a benefit determination under the policy, Unum has discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy." (R. at UACL00462.) Given this clear statement of discretionary authority, Defendants maintain that the court should apply the arbitrary and capricious standard in reviewing Unum's denial of Plaintiff's claim. Relying on *Bolden v. Unum Life Ins. Co. of Am., 2003 U.S. Dist. LEXIS 3288, No. 02 C 6701, 2003 WL 921764, (N.D. Ill. Mar. 6, 2003)*, however, Plaintiff contends that the Unum Policy does not clearly convey discretionary authority to the plan administrator. In *Bolden*, Judge Leinenweber concluded that a Unum disability policy did not contain a clear grant of discretionary authority to determine benefits eligibility. Specifically, the court noted that although the plan's Certificate of Coverage stated that Unum had discretionary authority to determine benefits eligibility and to interpret the terms and provisions under the act, the policy itself states that an employee is disabled when "Unum determines." *2003 U.S. Dist. LEXIS 3288, [WL] at *3*. The court concluded that while the former language was sufficient under *Herzberger*, the latter language within the policy was "clearly insufficient." *Id.* After concluding that these provisions were inconsistent, Judge Leinenweber applied the provision in the Certificate of Coverage stating "if the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern," and held that the default *de novo* standard should be applied. *Id.*

Although this plan contains the same linguistic discrepancy discussed in *Bolden*, this court is not convinced that the two provisions are inconsistent. As an initial matter, the first page of the policy states "this policy consists of: (1) all policy provisions and any amendments and/or attachments issued; (2) employee's signed applications, and

(3) the certificate of coverage." (R. at UACL00473.) Thus, the Certificate of Coverage is not distinct from the rest of the policy, but rather a part of it, and its provisions must be read as a part of the whole policy. It is only where "the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder)" that the terms of the latter will govern. (R. at UACL00462.) Here, the provisions of the Certificate are not "different," but merely supplemental.

The *Bolden* court notes that the language in "General Provisions" section of the policy, which states "you are disabled when Unum *determines that* . . . you are unable to perform the duties of any gainful occupation for which you are reasonable fitted by education, training or experience," (R. at UACL00458), is insufficient under *Herzberger* to rebut the presumption of plenary review. This court agrees with this conclusion. A determination that specific language is insufficient to rebut the default presumption does not require the conclusion that benefits determinations shall be reviewed on a *de novo* basis, however. Had the language in the General Provisions section stated affirmatively that benefit decisions were entitled to no discretion, the court would have no trouble concluding that the provision in the Certificate of Coverage is inconsistent and thus does not apply. In this case, however, the court reads the language in the Certificate as supplemental clarifying language that does not contradict any of the policy's general provisions (which, standing alone, are silent on the issue of standard of review), but merely seeks to explain them in "plain English." (R. at UACL00462). This is consistent with a decision of Magistrate Judge Denlow, who concluded that a Unum disability plan granted the administrator "the *discretion to determine* whether an applicant is disabled." *Crespo v. Unum Life Ins. Co. of America, 294 F. Supp. 2d 980, 990 n.3 (N.D. Ill. 2003).*

More importantly, the Seventh Circuit recently held that certificates of coverage are binding insurance plan documents. *Ruiz v. Cont'l Cas. Co.,400 F.3d 986, 2005 WL 566731 (7th Cir. Mar. 11, 2005)*. In *Ruiz*, the court examined whether a disability insurance plan granted the plan administrator discretionary authority to construe the term of the plan or determine eligibility for benefits. *400 F.3d 986, [WL] at *4*. The plan in question contained, like the Unum Plan, discretionary language within its certificate of coverage, but not in the body of the policy. *Id.* Regardless, the court held that a certificate of coverage is a plan documents, and thus that the language within the certificate was sufficient to confer discretionary authority on the plan administrator. *400 F.3d 986, [WL] at *5*.

In concluding that the Unum Policy vests discretion in the administrator, the court is mindful that the purpose of the *Herzberger* decision is to ensure that employee policyholders are given adequate notice of plan administrator's benefit determinations will be "largely insulated from judicial review by reason of being discretionary." *Herzberger, 205 F.3d at 332*. Under ERISA, a stipulation for deferential review "must be clear. . . . The employees are entitled to know what they're getting into, and so if the employer is going to reserve a broad, unchanneled discretion to deny claims, the employees should be told about this, and told clearly." *Id. at 332-33*. For the reasons explained above, the court finds that the combined language of the Certificate of Coverage and the General Provisions sections of the Unum Policy does clearly inform Plaintiff of Unum's discretion.[15]

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[15] A number of other Judges in this district have also concluded that this language was sufficient to convey discretionary authority to Unum. *See Shyman v. Unum Life Ins. Co. of Am.*, 2004 U.S. Dist. LEXIS 4964, No. 01 C 7366, 2004 WL 609280, *7 (N.D. Ill. Mar. 25, 2004) (Gottschall, J.); *Cheng v. Unum Life Ins. Co. of America*, 291 F. Supp. 2d 717, 719 (N.D. Ill. 2003) (Bucklo, J.); *Gingold v. UNUM Life Ins. Co. of Am.*, 2002 U.S. Dist. LEXIS 19581, No. 01 C 5420, 2002 WL 31307853, *4

Plaintiff also argues, in the alternative, that Unum has a conflict of interest as both the claims administrator and the insurer. *Beecher v. Conn. Gen. Life Ins. Co., 2002 U.S. Dist. LEXIS 22942, No. 01 C 7741, 2002 WL 31681473, *2 (N.D. Ill. Nov. 26, 2002)* (recognizing that company has a conflict of interest where serving as both claims administrator and the insurer). Such a conflict is considered as a factor when determining whether the administrator acted arbitrary and capriciously, *Hightshue v. AIG Life Ins. Co., 135 F.3d 1144, 1148 (7th Cir. 1998)*, but the Seventh Circuit has rejected the argument that the inherent conflict of interest is sufficient to alter the standard of review. *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan, 144 F.3d 1014, 1020 (7th Cir. 1998)*. Instead, courts presume that an administrator acts neutrally "unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." *Id., citing Cuddington v. Northern Ind. Public Serv. Co., 33 F.3d 813, 816 (7th Cir. 1994); Van Boxel v. Journal Co. Employees' Pension Trust, 836 F.2d 1048, 1051, 1053 (7th Cir. 1987)*. Plaintiff in this case has not presented any such evidence.

Under the arbitrary and capricious standard, an administrator's denial of benefits "will only be overturned if it is 'downright unreasonable.'" *Carr v. Gates Health Care Plan, 195 F.3d 292, 294 (7th Cir. 1999), quoting Butler v. Encyclopedia Britannica, Inc., 41 F.3d 285, 291 (7th Cir. 1994)*. In other words, an administrator's decision is final so

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(N.D. Ill. Oct. 15, 2002) (Aspen, J), *aff'd* 74 Fed. Appx. 660, 2003 WL 22025061 (7th Cir. 2003). The court cannot know, however, whether the policies at issue in these cases all contained identical language and terms as the policy at issue here, though they did all involve a Unum Long Term Disability Policy with the identical "discretionary authority" provision. It should also be noted that in many of these cases the plaintiffs do not appear to have argued that the language in the certification of coverage was inconsistent with that in the general policy provisions, but rather objected to the application of an arbitrary and capricious standard on other, if any, grounds.

long as the administrator "makes an informed judgment and articulates an explanation for it that is satisfactory in light of the relevant facts," *Id.*, and a denial of benefits will not be set aside if based upon "a reasonable interpretation of plan documents." *Id., citing Loyola Univ. of Chicago v. Humana Ins. Co., 996 F.2d 895, 898 (7th Cir. 1993)*. Thus, in applying the arbitrary and capricious standard, it is not the function of the courts "to decide whether we would reach the same conclusion as the Plan or even rely on the same authority," but rather merely to determine whether the decision was "downright unreasonable." *Carr, 195 F.3d at 294-95, quoting Cvelbar v. CBI Ill. Inc., 106 F.3d 1368, 1379 (7th Cir. 1997); Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan, 144 F.3d 1014, 1021 (7th Cir. 1998)*. Nevertheless, "deferential review is not no review," and "deference need not be abject." *Gallo v. Amoco Corp., 102 F.3d 918, 922 (7th Cir. 1996); Swaback v. American Info. Techs. Corp., 103 F.3d 535, 540 (7th Cir. 1996)* ("Although we review the [plan administrator's] actions in a deferential light, we shall not rubber stamp their decisions.").

Despite the deference accorded an insurer's denial under this standard, an administrator's discretion is not unlimited. ERISA requires a "full and fair" assessment of claims and clear communication to the claimant of the "specific reasons" for benefits denials. *29 U.S.C. § 1133, 29 C.F.R. § 2560.503-1*. Thus, a benefits denial will be overturned if it is unreasonable or if the administrator fails to afford the claimant a "full and fair review." *See Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3d 914, 919 (7th Cir. 2003)*(reversing denial of long-term disability claim based on fibromyalgia under discretionary standard); *Crespo, 294 F. Supp. 2d at 994*.

III. Unum's Denial of Claim

Notwithstanding the deference granted Unum's decision, the court remains uncertain that the decision is supported by the record. Unum based its denial of benefits on the grounds that despite Plaintiff's ailments, there was no evidence that he could not perform sedentary level work. In reaching its decision, however, it appears that Unum (1) relied on the conclusory and unsupported opinions of in-house doctors who had not examined Plaintiff; (2) relied on opinions of in-house doctors who had not examined plaintiff and who did not explain their basis for disagreement with the conclusions reached by Plaintiff's treating physicians; (3) failed to contact Plaintiff's treating physicians to discuss their diagnoses; (4) failed to refer Plaintiff to an independent medical expert for examination; and (5) ignored (or at least made no mention of) evidence and reports presented by Plaintiff's treating physicians. Although courts have held that these factors individually do not require a finding that Unum's decision was arbitrary and capricious, the combination of these factors here leads the court to conclude that Unum failed to conduct a full and fair review of Plaintiff's disability claim.

Unum based its denial of benefits on the ground that, despite Plaintiff's ailments, there was no evidence that he could not perform sedentary level work. In reaching this conclusion, however, Unum dismissed the reports of two of Plaintiff's treating physicians that Plaintiff was disabled due to the cumulative effects of a number of ailments, and repeatedly ignored evidence of Plaintiff's deteriorating physical condition.[16] In support of his original claim for

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[16] Plaintiff also contends that Unum failed to properly consider the Social Security Administration's finding of disability on July 16, 2001. For purposes of this case, however, the SSDI award is not helpful because the award letter does not specify whether the approval or Plaintiff's application was based on a mental and/or physical disability. Unum does not here challenge the Plaintiff's claim of mental disability. Moreover, the Social Security file was not presented to Unum, and thus

disability benefits based on his physical disability, Plaintiff submitted reports in May and June 2001 from Ors. Myers and Raymond stating that he suffered from spinal stenosis. Specifically, Dr. Myers concluded that the combination of Plaintiff's spinal stenosis and his polio "has resulted in permanent disability." (R. at UACL00306.) Dr. Myers also noted that "cannot stand or walk for any distance and has significant lower extremity weakness." (*Id.*) Dr. Raymond similarly concluded that Plaintiff suffered from spinal stenosis, sleep apnea, and post-polio syndrome. (R. at UCAL00314-00312.) Upon receipt of these reports, one of Unum's in-house consultants. Dr. Thomas, concluded that although there "are objective findings of weakness and toss of reflex," Plaintiff does not have a "significant impairment that would affect claimant in regards to work as a salesman or sales manager." (R. at UACL00359.) Although Dr. Thomas briefly mentioned the results of an EMG test, he did not explain his conclusion that Plaintiff was not disabled, nor did he discuss the basis for his disagreement with Dr. Myers's and Raymond's diagnosis.

Similarly, Dr. Feagin reviewed the reports submitted by Plaintiff and concluded that Plaintiff did not suffer from post-polio syndrome and that he was not disabled. (R. at UACL00378.) While Dr. Feagin cited the "electromagnetic studies" which showed no "active denervation" for his conclusion that Plaintiff did not suffer from post-polio syndrome, he did not explain his reasons for concluding that Plaintiff could work, nor did he even mention Dr. Myers's report. (*Id.*) The only explanation provided by Dr. Feagin was that Plaintiff had contracted polio at age seven and had

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could not have been considered during its benefits determination. *See Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th cir. 1994) (plan administrator did not err in failing to consider Social Security Administration determinations where Social Security file had not been presented to plan administrator, because the administration "was bound only to consider what evidence and information it had before it").

worked his entire life with the lingering symptoms. (R. at UACL00378.) In the court's view, this statement shows that Dr. Feagin failed to appreciate or consider the multiple impairments – "stenosis superimposed on polio" -- that were the basis for Dr. Myers's conclusion that Plaintiff was disabled. Indeed, none of Unum's reviewing professionals attempted to explain their bases for not accepting Dr. Myers's diagnosis at face value. Nor did any of Unum's medical professionals discuss Dr. Myers's statement that Plaintiff "cannot stand or walk for any distance" and suffers from "significant lower extremity weakness," (R. at UACL00306), or attempt to explain why this diagnosis was or was not accurate. Instead, the Unum reports provide one-sentence statements that whatever Plaintiff's physical problems, he can work.

Dr. Raymond submitted an additional report in May 2002 in which he concluded that Plaintiff was disabled due to a combination of post-polio syndrome, stroke, coronary heart disease, diabetes, and anticardiolipin antibody syndrome. (R. at UACL00591.) In his supporting statement, Dr. Raymond stated that Plaintiff could not "lift, bend, carry, walk, [or] climb" and that he anticipated no improvement in Plaintiff's condition. (*Id.*) Dr. Feagin reviewed this new report on behalf Of Unum, concluding without explanation that his "prior conclusions remained unchanged." (R. at UACL00596.) Again, Dr. Feagin did not discuss Dr. Raymond's conclusion that Plaintiff was disabled and unable to walk without assistance, nor offer any explanation of his reasons for concluding otherwise.

The administrative record reflects a pattern in which Unum doctors briefly discuss the medical testing (in a sentence or two), and then conclude "but Plaintiff's impairments do not render him physically unable to perform sedentary work." At no point do they attempt to explain their own conclusions or their basis for disagreeing with the

conclusions of Plaintiff's treating physicians. The failure of Unum's doctors to articulate their reasons for rejecting the conclusions of Plaintiff's treating physicians leave the reviewing court with little or no basis for evaluation their decision to deny Plaintiff's claim. *See Carr, 195 F.3d at 294* (Under the arbitrary and capricious standard, an administrator's decision is final *so long as* he "makes an informed judgment and articulates an explanation for it that is satisfactory in light of the relevant facts.").

The conclusory opinions offered by Unum's in-house doctors are especially troubling in light of the fact that Unum's doctors neither examined Plaintiff nor spoke with his treating physicians. Under ERISA, there is no "treating physician rule" that requires plan administrators to grant special weight to the opinions of a claimant's treating physician. *Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834, 155 L. Ed. 2d 1034, 123 S. Ct. 1965 (2003).* Nevertheless, a plan administrator "may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." *Id.* In *Nord,* a physician hired by the plan administrator examined an individual claiming disability. Contrary to the findings of the claimant's treating physician, the plan administrator's doctor concluded that the claimant could perform sedentary work with the aid of medication. The Supreme Court held that the plan administrator need not give more weight to the findings of the claimant's treating physician than those of doctors hired by the plan. Importantly, however, the plan administrator relied on the opinions of an independent outside consultant, who personally examined the claimant. In contrast, Unum has not had Plaintiff examined by its own physician, nor has it relied on independent consultants. Rather, Unum has merely had its own in-house physicians conduct a paper review of Plaintiff's file.

Although plan administrators are not required to seek independent medical evaluations, *Wallace v. Reliance Standard Life Ins. Co., 318 F.3d 723, 724 (7th Cir. 2003)*, courts have repeatedly held that such an independent evaluation is evidence of a thorough investigation of a claim. *Hightshue v. AIG Life Ins. Co., 135 F.3d 1144, 1148 (7th Cir. 2003)* ("Seeking independent expert advice is evidence of a thorough investigation"); *Crespo v. Unum Life Ins. Co., 294 F. Supp. 2d 980, 995 (N.D. III. 2003)*("Seeking independent expert advice is evidence of a thorough investigation, and reliance upon independent experts generally insulates the fiduciary from judicial reversal."). Courts have also been critical where plan administrators fail to attempt to contact treating physicians to discuss any concerns they might have regarding a claimed disability. *Crespo, 294 F. Supp. 2d at 994* ("Unum did not make a full and fair assessment of [plaintiff's] claims because it did not contact any of her treating physicians to discuss its concerns."); *Di Pietro v. Prudential Ins. Co. of Am., 2004 U.S. Dist. LEXIS 5004, No. 03 C 1018, 2004 WL 626818, *7 (N.D. III. Mar. 26, 2004)* (reversing insurer's denial of benefits under arbitrary and capricious standard of review where there had been no independent medical examination and insurer's consultants had not spoken with claimant's treating physicians). Indeed, this court has found no case within the Seventh Circuit in which a court upheld a claims denial where the claimant's treating physicians all agreed[17]

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[17] Defendants now maintain that one of Plaintiff's treating physician, neurologist Dr. Levy, concluded that Plaintiffs problems stemmed entirely from psychiatric problems. (Defendants' Reply Brief, at 9.) While it is true that Dr. Levy concluded that "depression is causing his symptoms," this diagnosis was made in May 2000. there is much evidence that since that time, Plaintiff's physical condition has deteriorated. Indeed, Dr. Levy examined Plaintiff a full year before Plaintiff was diagnosed with spinal stenosis and post-polio syndrome by Drs. Myers and Raymond. The fact that Unum continues to cite Dr. Levy's four-year old comment shows it has failed to consider the

he was disabled and in which the plan administrator did not (1) examine Plaintiff, (2) refer Plaintiff to an independent medical expert for examination, nor (3) have its in-house physicians at least contact the claimant's treating physicians. In the absence of any such steps, or of a full explanation for rejecting the conclusions of Plaintiff's treating physicians and concluding that Plaintiff was not disabled, the court is uncertain whether the plan administrator simply denied the claim as a matter of course.

As Plaintiff points out, Unum's review of his claim resembles that found to be arbitrary and capricious in *Crespo v. Unum Life Ins. Co., 294 F. Supp. 2d 980 (N.D. Ill. 2003).* In *Crespo,* plaintiff submitted a claim for disability claimants on the basis of fibromyalgia, "a common, but elusive and mysterious disease . . . [causing] 'pain all over,' fatigue, disturbed sleep, stiffness, and . . . multiple tender spots." *Crespo, 294 F. Supp. 2d at 983.* In support of her claim, plaintiff submitted reports from a number of treating physicians who concluded that she was disabled and unable to work due to the disease. *Id. at 984-87.* Unum rejected plaintiff's claim after an in-house nurse and doctor reviewed plaintiff's file and concluded that there was no evidence that plaintiff could not work. *Id. at 987.* At no point did Unum's doctors attempt to contact plaintiff's treating physicians. *Id.* Reviewing the denial under the arbitrary and capricious standard, Magistrate Judge Denlow concluded that the insurer's claims investigation was lacking in a number of areas. Among the errors made by Unum, Judge Denlow noted that the company (1) did not consider the reports submitted by two of plaintiff's treating physicians, (2) failed

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substantial evidence that Plaintiff's condition has significantly deteriorated since his initial claim in 2000. In any case, although the plan does not provide for disability benefits for a mental disability that exceeds 24 months in duration, the plan does not appear to exclude coverage for physical disabilities merely because a mental condition is the root cause of the physical problems.

to contact any of plaintiff's treating physicians to discuss its concerns; and (3) did not refer plaintiff for an independent examination nor submit her records for an independent examination. *Id. at 994-96.*

Unum's present denial of benefits bears close resemblance to that in *Crespo.* As in *Crespo,* Unum here based its decision entirely on the conclusions of its own in-house doctors who never examined Plaintiff nor made any effort to discuss his condition with his treating physicians. As Judge Denlow noted:

> In light of the reports from [claimant's] treating and consulting physicians, Unum easily could have resolved any doubts it may have had by requiring [claimant] to be examined by an independent medical expert or at a minimum to have her medical records reviewed by an independent medical expert, who could contact her treating physicians to clarify any questions.

Id. at 996. Furthermore, in this case, as in *Crespo,* Unum failed to consider all medical evidence submitted by Plaintiff. Specifically, Unum both failed to consider the cumulative effect of Plaintiff's multiple physical impairments and failed to consider certain impairments discussed by his treating physicians. After Unum's initial denial of his claim, Plaintiff submitted additional materials in support of his disability claim. These reports discussed additional physical impairments not previously examined by Unum. Specifically, during his appeal, Plaintiff submitted a letter from Dr. Raymond specifying that the combined effect of his multiple impairments rendered him disabled. Dr. Raymond listed a total of ten impairments -- including diabetes, lumbar

spinal stenosis, carpal tunnel syndrome, post-polio syndrome, and sleep apnea -- and concluded that the cumulative effect of these impairments rendered him disabled. (R. at UACL00658-00659.) In rejecting this appeal, Dr. Fluter, one of Unum's in-house physicians, stated that Dr. Raymond's letter contained "no additional information regarding claimant's orthopedic and neurologic status." (R. at UACL00665.) Yet, Unum had not yet considered the carpal tunnel diagnosis, as required for a full and fair review. Such a review, under ERISA regulations "takes into account all comments, documents, records. and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination." *29 C.F.R. § 2560.503-1(h)(4)*; *Crespo, 294 F. Supp. 2d at 995*. None of Unum's in-house doctors ever discussed or examined Dr. Raymond's carpal tunnel diagnosis. In light of this, Dr. Fluter's statement that claimant had submitted "no additional information" is conclusory and insufficient. *See Nord, 538 U.S. at 823* ("Plan administrators may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician.").

Had Unum referred Plaintiff to an independent medical expert, and had that independent expert concluded that Plaintiff's physical impairments do not render him unable to perform sedentary work, the court would likely have little trouble upholding its denial of benefits. *See Donato v. Metropolitan Life Ins. Co., 19 F.3d 375, 380 (7th Cir. 1994)*(holding that an insurance company made a permissible choice in relying upon independent medical consultant over claimant's physicians); *Anderson v. Operative Platerers' & Cement Masons' Int'l Ass'n Local No. 12 Pension & Welfare Plans, 991 F.2d 356, 358 (7th Cir. 1993)*(upholding pension fund's denial of benefits where the fund relied upon an examination conducted by an independent orthopedic surgeon). In the absence of an

independent examination, however, Unum relies on a mere paper review of Plaintiff's claims, which, under the circumstances presented here, is inadequate.

IV. Remand

Having concluded that the denial of Plaintiff's disability claim was arbitrary and capricious, the court must determine the appropriate remedy. In the ERISA context, the Seventh Circuit has recognized a distinction between cases dealing with a plan administrator's initial denial of benefits and cases in which a plan administrator terminates benefits to which the administrator had previously determined the claimant was entitled. *Hackett v. Xerox Corp. Long-Term Disability Income Plan, 315 F.3d 771, 775 (7th Cir. 2003).* This distinction seeks to shape the remedy for the defective procedures in light of the *status quo* prior to the denial or termination. *Id., citing Quinn v. Blue Cross & Blue Shield Ass'n, 161 F.3d 472 (7th Cir. 1998).* Thus, in cases in which the plan administrator did not employ adequate procedures in its initial denial of benefits, the appropriate remedy is to remand the case to the plan administrator. *Hackett, 315 F.3d at 776, citing Wolfe v. J.C. Penney Co., 710 F.2d 388, 394 (7th Cir. 1983).* If the claimant prevails on remand, he would be entitled to retroactive benefits from the time at which the initial denial occurred. *Id.* But the court is not allowed to "substitute its own judgment for that of the administrator," *Hackett, 315 F.3d at 776, citing Quinn, 161 F.3d at 478, Gallo v. Amoco Corp., 102 F.3d 918, 923 (7th Cir. 1996),* nor is the claimant "automatically entitled to benefits." *Hackett, 315 F.3d at 776; Quinn, 161 F.3d at 478* (automatic award of benefits would not restore *status quo,* but might provide the claimant "with an economic windfall should she be determined not disabled upon a proper reconsideration").

In cases in which the plan administrator terminated benefits under defective procedures, however, the *status quo*

prior to the defective procedure was the continuation of benefits. *Hackett, 315 F.3d at 776.* Thus, the proper remedy upon finding that the plan administrator employed acted arbitrarily and capriciously in terminating benefits is the reinstatement of benefits. *Id; Halpin v. W.W. Grainger, Inc., 962 F.2d 685, 697 (7th Cir. 1992)*(reinstating benefits after plan administrator had arbitrarily and capriciously terminated benefits). In general, reinstatement is appropriate in cases "involving claimants who were receiving disability benefits, and, but for their employers' arbitrary and capricious conduct, would have continued to receive benefits." *Quinn, 161 F.3d at 477*; *Hackett, 315 F.3d at 776.*

Although Plaintiff had been receiving disability benefits under the Unum Plan on the basis of a mental disability, the present case involves a benefits denial, not a termination. Prior to his second disability claim, Plaintiff's benefits were scheduled to, and did, expire in July 2002, pursuant to the Unum Plan's 24-month coverage limitation disabilities based on mental illness. Thus, Unum's arbitrary and capricious review involved a denial of Plaintiff's second benefits claim, not the termination of his initial claim. This distinction is explained in *Quinn,* where the court dealt with an administrator's denial of continuing benefits under a plan in which the benefits automatically expired unless the administrator reviewed an approved a claim for continuance. *Quinn, 161 F.3d at 477.* In finding that the case should be remanded to the plan administrator, the court noted that unlike cases involving a straight termination of benefits, "Quinn was not scheduled to continue receiving benefits under the program." *Id. at 478.*

The Seventh Circuit has held that remand is unnecessary, even under the arbitrary and capricious standard of review, when "the case is so clear cut that it would be unreasonable for the plan administrator to deny the application for benefits on any ground." *Hess v. Hartford Life & Accident Ins. Co.,*

274 F.3d 456, 464 (7th Cir. 2001). The court does not believe that this case falls into that category, however. One unfortunate aspect of Unum's failure to refer Plaintiff for an independent medical examination is that, as the court noted previously, had an independent medical expert examined Plaintiff and concluded that he was physically able to perform sedentary work, a subsequent denial of benefits would likely have been unassailable. This is not a case in which the court "there is no evidence in the record to support a . . . denial of benefits." *Quinn, 161 F.3d at 477.* In their review of the file, Unum's in-house doctors did discuss Plaintiff's medical testing and (implicitly) suggested that the objective results did not indicate that Plaintiff cannot perform sedentary work.

The parties have presented this court with a series of medical reports -- some prepared by doctors who examined Plaintiff, others by doctors who, in turn, examined only the treating doctors' reports. Unfortunately, the two sets of doctors came to the opposite conclusions. Even more unfortunately, the latter doctors did not fully explain why they rejected the conclusions of the treating physicians. In light of this uncertainty, the court believes it proper to remand the case to the plan administrator for further investigation into the merits of Plaintiff's disability claim. *See Quinn, 161 F.3d at 478* (remanding whether denial of benefits "was arbitrary and capricious, but not necessarily wrong"); *Cheng v. Unum Life Ins. Co. of America, 291 F. Supp. 2d 717, 721 (N.D. Ill. 2003)* (remanding where "it is not clear one way or the other whether [claimant] is entitled to benefits").

CONCLUSION

For the reasons explained above, Defendants' motion for summary judgment (Doc. No. 14) is denied and Plaintiff's motion for summary judgment (Doc. No. 12) is granted. The case is hereby remanded to the Unum Plan administrator for

further review of the merits of Plaintiff's disability claim in accordance with this opinion.

ENTER:

Dated: March 31, 2005

REBECCA R. PALLMEYER

United States District Judge

JUDGMENT IN A CIVIL CASE

Decision by Court. This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS HEREBY ORDERED AND ADJUDGED that Defendants' motion for summary judgment is denied and Plaintiff's motion for summary judgment is granted. The case is hereby remanded to the Unum Plan Administrator for further review of the merits of Plaintiff's disability claim in accordance with this opinion.
Date: 3/31/2005

IN THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

WILLIAM C. DAVIS, Plaintiff-Appellant, Cross-Appellee,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA, and REGAL-BELOIT CORPORATION LONG TERM DISABILITY PLAN, Defendants-Appellees, Cross-Appellants.

Nos. 05-2001 & 05-2165

444 F.3d 569

April 24, 2006, Decided

COUNSEL: For WILLIAM C. DAVIS, Plaintiff: Mark D. Debofsky, DALEY DEBOFSKY & BRYANT, Chicago, IL USA.

For UNUM LIFE INSURANCE COMPANY OF AMERICA, REGAL-BELOIT CORPORATION LONG TERM DISABILITY PLAN, Defendants: Michael J. Smith, Attorney at Law, Chicago, IL; Steven R. McMannon, W. Sebastian von Schleicher, MICHAEL J. SMITH & ASSOCIATES , Chicago, IL USA.

OPINION: ORDER

FLAUM, *Chief Judge*, EASTERBROOK, *Circuit*

Judge, and MANION, *Circuit Judge*. On consideration of the petition for rehearing en banc filed by appellant, no judge in active service has requested a vote on the petition for rehearing en banc,* and all of the judges on the original panel have voted to deny rehearing. The petition is therefore DENIED.

* Judge Rovner did not participate in the consideration of this matter.